Supreme Court, U.S.
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No. 06-651 NOV 7 - 2006

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In The

Supreme Court of the United States

ELIZABETH MELLEY and JEAN MIKULIS,

Petitioners,

v.

BLUE CROSS AND BLUE SHIELD OF NORTHEASTERN PENNSYLVANIA,

Respondent.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Third Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED FOR REVIEW

Whether the United States Supreme Court should grant certiorari to resolve the conflict among the Circuits with respect to the interpretation of *Firestone Tire & Rubber Co., et al. v. Bruch*, 489 U.S. 101, 109 S. Ct. 948, 103 L. Ed. 2d 80 (1989), concerning the standing of a retiree and the widow of a retiree to challenge the termination of their health care benefits in a breach of fiduciary duty claim under the Employee Retirement Income Security Act of 1974 (ERISA) (29 U.S.C. § 1001, et seq.), when it is the allegedly improper plan amendment itself which purports to terminate the benefits for the retiree and the widow, thus depriving them of standing which existed previous to the amendment, and their claims are colorable?

Whether the Supreme Court's decision in *Firestone Tire & Rubber Co. et al. v. Bruch et al.*, 489 U.S. 101, 109 S. Ct. 948, 103 L. Ed. 2d 80 (1989), supports standing for a retiree and the widow of a retiree to challenge the termination of their health benefits in a breach of fiduciary duty claim under ERISA when the breach of fiduciary duty arises from systematic and repeated false promises that health benefits under an ERISA plan would be fully funded for the life of the retiree and the widow of a retiree, when an amendment to the plan purports to terminate all benefits for the retiree and the widow due under the plan, and when the retiree and the widow provide evidence of reasonable, foreseeable and detrimental reliance upon the promise of fully funded lifetime health benefits?

Whether a retiree has standing to challenge the termination of her health benefits in a breach of fiduciary

QUESTIONS PRESENTED FOR REVIEW – Continued

duty claim under ERISA when she would be receiving health benefits but for her early retirement, which was solely induced by the employer's false promise to continue fully funded lifetime health benefits if she retired at a time when she had almost thirteen years of service, and thereafter the employer amends the plan to exclude benefits to those who retired with fewer than fifteen years of service?

PARTIES TO THE PROCEEDING

The parties to the proceeding are:

The Petitioners are Elizabeth Melley and Jean Mikulis. They were the appellants before the United States Court of Appeals for the Third Circuit.

Frank W. Leuthner and William Reasner initiated suit in the United States District Court for the Middle District of Pennsylvania at docket number 42-cv-1709. Elizabeth Melley and Jean Mikulis were granted intervenor status in that action. Frank W. Leuthner and William Reasner's claims are currently pending before the United States District Court for the Middle District of Pennsylvania. They do not have an interest in the instant action.

The Respondent is Blue Cross of Northeastern Pennsylvania.

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CITATIONS OF REPORTS OF OPINIONS ENTERED IN THE CASE

United States Court of Appeals for the Third Circuit:

Leuthner v. Blue Cross & Blue Shield of N.E. Pa., 454 F.3d 120 (3d Cir. 2006)

United States District Court for the Middle District of Pennsylvania:

Leuthner v. Blue Cross & Blue Shield of N.E. Pa., 270 F.Supp. 2d 584 (M.D. Pa. 2003) (Granting Defendant's Motion for Summary Judgment)

Leuthner v. Blue Cross & Blue Shield of N.E. Pa., No. 4:02-cv-1709, slip op. (M.D. Pa. Nov. 13, 2003) (Denying class certification)

Melley v. Blue Cross & Blue Shield of N.E. Pa., No. 4:02-cv-1709, slip op. (M.D. Pa. May 7, 2004) (Denying Elizabeth Melley standing and requiring Jean Mikulis to file a second amended complaint)

Melley v. Blue Cross & Blue Shield of N.E. Pa., No. 4:02-cv-1709, slip op. (M.D. Pa. Sept. 27, 2004) (Denying Jean Mikulis standing)

Leuthner v. Blue Cross & Blue Shield of N.E. Pa., No. 4:02-cv-1709, slip op. (M.D. Pa. Nov. 12, 2004) (Certifying the May 7, 2004 and September 27, 2004 Orders as final judgments)

BASIS FOR SUPREME COURT JURISDICTION

The United States Court of Appeals for the Third Circuit entered its judgment on July 10, 2006. App. 22. Petitioners Elizabeth Melley and Jean Mikulis seek review of that judgment on a writ of certiorari.

On July 21, 2006, Petitioners timely filed a petition for rehearing and rehearing en banc in the United States Court of Appeals for the Third Circuit. On August 9, 2006, the Court of Appeals filed an Order denying the petition. App. 72. The present petition for writ of certiorari is timely filed under 28 U.S.C. § 2101(c) and under Rule 13.3 of this Court.

The Supreme Court of the United States has jurisdiction pursuant to 28 U.S.C. § 1254(1) to consider this petition for writ of certiorari from a judgment entered by the United States Court of Appeals for the Third Circuit, with an opinion filed on July 10, 2006, in *Leuthner v. Blue Cross & Blue Shield of N.E. Pa.*, 454 F.3d 120 (3d Cir. 2006).

STATUTES INVOLVED IN THE CASE

The statutes involved are promulgated under The Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, et seq., and specifically 29 U.S.C. § 1132(a); 29 U.S.C. § 1002(7); 29 U.S.C. § 1002(8). The text of 29 U.S.C. § 1132(a) is set forth in the Appendix. App. 74. The text of 29 U.S.C. § 1002(7) and 29 U.S.C. § 1002(8) are found below:

> For the purposes of this subchapter:
>
> . . . (7) The term "participant" means any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.

29 U.S.C. § 1002(7).

> For the purposes of this subchapter:
>
> . . . (8) The term "beneficiary" means a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder.

29 U.S.C. § 1002(8).

STATEMENT OF THE CASE

A. Jurisdiction

This is a writ of certiorari to the Supreme Court of the United States pursuant to 28 U.S.C. § 1254(1) from a judgment entered by the United States Court of Appeals for the Third Circuit. *Leuthner v. Blue Cross & Blue Shield of N.E. Pa.*, 454 F.3d 120 (3d Cir. 2006). The United States Court of Appeals for the Third Circuit exercised jurisdiction pursuant to 28 U.S.C. § 1291 over an appeal from a final decision of the District Court entered pursuant to Federal Rule of Civil Procedure 54(b). Pursuant to 28 U.S.C. § 1331, the District Court exercised subject-matter

jurisdiction under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, et seq. 29 U.S.C. § 1132(e) provides for jurisdiction in the United States District Courts.

B. Nature of the Case

The United States Court of Appeals for the Third Circuit affirmed the District Court's dismissal of a complaint for lack of standing of a retiree and a widow of a retiree to bring a breach of fiduciary duty claim. *Leuthner*, 454 F.3d at 122. Petitioners seek reversal of the denial of standing so that they may proceed with their breach of fiduciary duty claims.

C. The Parties

The Respondent is Blue Cross of Northeastern Pennsylvania ("Blue Cross") and a provider of health insurance. App. 77, 79, 99. Blue Cross administers an employee welfare health insurance plan ("Plan") for its retirees. The Plan is governed by ERISA, with Blue Cross as the plan fiduciary under 29 U.S.C. § 1002(21)(A). *Leuthner*, 454 F.3d at 122.

The Petitioners are Jean Mikulis and Elizabeth Melley. Jean Mikulis ("Ms. Mikulis") is a retired Blue Cross employee. App. 77, 99. Elizabeth Melley ("Mrs. Melley") is the wife of a deceased, retired Blue Cross employee. App. 48, 77, 78.

Both Ms. Mikulis and Mrs. Melley received benefits under the Plan until Blue Cross breached its promise to provide them with fully funded health benefits and terminated their benefits by an amendment to the Plan that

became effective on January 1, 2001. *Leuthner*, 454 F.3d at 123. App. 79, 84-85, 86, 87-88.

D. The Promise

For over half a century, Blue Cross promised and provided its employees with lifetime health insurance. From 1939 until 2000, Blue Cross promised and maintained a policy and practice of providing all employees with lifetime health insurance coverage and above average retirement benefits. App. 79, 100. The promise of employer paid health insurance for life provided an incentive to retain employees without increased salary demands or unionizing. App. 79, 101. Within this backdrop of well established practice and tradition, prior to January 1, 2001, agents of Blue Cross, acting as fiduciaries of the Plan, promised employees that their Plan health insurance benefits would be fully funded by Blue Cross for the remainder of their lives and the remainder of the lives of their dependents entitled to benefits under the Plan. App. 84, 100-101. Blue Cross represented to Ms. Mikulis and other employees that they were entitled to lifetime health insurance benefits fully paid for by Blue Cross, without any reference to its purported reservation of the right to reduce or eliminate benefits. App. 87-88, 100. To the contrary, Blue Cross assured Ms. Mikulis and other employees that they would be able to keep their benefits without any future changes, even after retirement. App. 84, 87-88, 101.

E. The Detrimental Reliance

Ms. Mikulis retired early because of false information provided about her Plan benefits by Blue Cross. Blue

Cross advised Ms. Mikulis and other employees verbally and by a written memorandum that they had to retire by April 1, 1993, in order to be eligible for the promised lifetime, one hundred percent company paid health insurance coverage for participants and beneficiaries without regard to the number of years employed. App. 102. Blue Cross further advised Ms. Mikulis and other employees that if they failed to retire by April 1, 1993, their future retirement health benefits would be based upon a percentage formula computed from years of employment. App. 102. As a result, in order to retain a continuation of fully funded lifetime health benefits, Ms. Mikulis, at the age of 62, with almost thirteen years of service with Blue Cross, made the decision to retire by April 1, 1993, based primarily on the promise and assurance of fully funded employer provided lifetime retirement health benefits. *Leuthner*, 454 F.3d at 123. App. 102-103. When counseling Ms. Mikulis and others similarly situated, Blue Cross never mentioned that it purported to retain a right to amend the provision of health benefits. App. 109. To the contrary, Blue Cross provided assurance to Ms. Mikulis and other employees that they would be able to keep their benefits without any future changes, even after retirement.

Ms. Mikulis did not want to retire by April 1, 1993; she loved her job and wanted to remain employed by the employer. App. 103. Ms. Mikulis and others similarly situated felt that they had no choice but to retire by April 1, 1993, in order to preserve their benefit of fully funded health insurance. App. 103. By retiring early, Ms. Mikulis and those similarly situated received a smaller pension and reduced Social Security benefits to which they would have otherwise been entitled. App. 103. Had Ms. Mikulis known that Blue Cross would eliminate her health

insurance, she would have remained employed by Blue Cross longer and saved more in anticipation of having to pay for health insurance in her retirement. App. 103. Ms. Mikulis and other employees relied upon Blue Cross's promise of employer-paid lifetime health insurance benefits as a predominate factor in making decisions about when to retire. App. 101-103.

Similarly, Mr. and Mrs. Melley made decisions about employment and retirement based upon false information provided by Blue Cross. Mrs. Melley's husband, as a retiree similarly situated to employees such as Ms. Mikulis, made decisions about retirement and health benefits based upon the promise of continuing lifetime health benefits for his spouse, even in the event of his death. App. 77, 87, 92, 94, 102-103, 111. Likewise, it is reasonable to infer that Mrs. Melley relied upon and made decisions regarding her own employment, retirement and health benefits based upon her belief that her health benefits under her husband's Plan would continue for the rest of her life as promised and upon the decisions of her deceased spouse to provide for their retirement. App. 92-93.

F. Reasonableness of Reliance

Ms. Mikulis, Mr. Melley, Mrs. Melley and other employees, retirees and beneficiaries reasonably believed Blue Cross's false promise of fully funded health benefits. Blue Cross had a well-established long tradition for over half a century of promising and providing its employees with lifetime health insurance. App. 79, 93, 100, 101. Agents of Blue Cross promised employees that their Plan health insurance benefits would be fully funded by Blue Cross for the remainder of their lives and the remainder of

the lives of their dependents entitled to benefits under the plan. App. 87, 100. Blue Cross is in the business of providing health insurance. App. 77, 79, 99, 100. Even after Blue Cross started to change some of its retirement benefits, it was reasonable to believe that changes would only apply to future retirees and not retroactively because Blue Cross had a policy and practice of applying changes only prospectively to future retirees, and not retroactively to those who had already retired. The 1993 and 1999 Plan amendments affected only future retirees who retired after the changes went into effect. App. 82, 105-108. Given Blue Cross's policy and procedure of only applying changes prospectively to future retirees, when Blue Cross issued a new Summary Plan Description (SPD) effective August 1, 1998 which included a section concerning the employer's right to modify or eliminate coverage, Ms. Mikluis and others similarly situated, including Mrs. Melley, reasonably believed that changes to retiree health insurance coverage would not apply to them as current retirees, spouses of current retirees and current surviving spouses. Indeed, when further changes were made to the medical benefits under the Plan in March 1999, notice was made that such changes applied only to future retirees and did not impact current retirees. App. 81-82, 106.

G. The ERISA Health and Welfare Benefits Plan

Blue Cross's health benefits plan provided fully funded health benefits for all of its retirees without regard to years of service until 1993. *Leuthner*, 454 F.3d at 122. In 1993, Blue Cross amended the Plan even though the Plan was devoid of any language providing notice that Blue Cross reserved the right to amend, reduce or eliminate benefits. App. 79, 102. In November 1992, Blue Cross

advised Ms. Mikulis and other employees verbally and by a written memorandum that they had to retire by April 1, 1993, in order to be eligible for the promised lifetime, one hundred percent paid health insurance coverage for participants and beneficiaries without regard to the number of years employed. App. 102. Blue Cross advised Ms. Mikulis and other employees that if they failed to retire by April 1, 1993, their future retirement benefits would be based upon a percentage formula computed from years of employment. App. 102. In 1999, Blue Cross amended the Plan's medical benefits, but notice was made that such changes applied only to future retirees and did not impact current retirees. App. 81-82, 106.

Blue Cross subsequently amended the Plan effective January 1, 2001. This amendment eliminated benefits for surviving spouses of retirees and eliminated benefits to retirees with fewer than fifteen years of service with Blue Cross. *Leuthner*, 454 F.3d at 123. It also applied retrospectively to current retirees and other beneficiaries who were already receiving benefits. *Id.*, at 123. Thus, Blue Cross terminated all health benefits, effective January 1, 2001, to Ms. Mikulis, a retiree with fewer than fifteen years of service with Blue Cross, and to Mrs. Melley, a surviving widow of a retiree. Since they were no longer receiving or expressly allowed to receive benefits under the terms of the amended Plan, the district court determined that they lacked standing to bring a breach of fiduciary duty claim. *See Melley v. Blue Cross & Blue Shield of N.E. Pa.*, No. 4:02-cv-1709, slip op. (M.D. Pa. May 7, 2004) (denying Elizabeth Melley standing and requiring Jean Mikulis to file a second amended complaint) (App. 46), and *Melley v. Blue Cross & Blue Shield of N.E. Pa.*, No. 4:02-cv-1709, slip op. (M.D. Pa. Sept. 27,

2004) (Denying Jean Mikulis standing) (App. 58). The Third Circuit Court of Appeals affirmed. *Leuthner v. Blue Cross & Blue Shield of N.E. Pa.*, 454 F.3d 120 (3d Cir. 2006).

ARGUMENT

The United States Supreme Court should grant a petition for writ of certiorari to resolve conflict among the Courts of Appeals as to the interpretation of *Firestone Tire & Rubber Co. et al. v. Bruch et al.*, 489 U.S. 101, 109 S. Ct. 948, 103 L. Ed. 2d 80 (1989), with respect to who has standing to sue for breach of fiduciary duty under ERISA. This conflict in the method of applying standing principles such as those outlined in *Firestone* suggests that there is a conflict among the Circuits – and even within the circuits – as to who has standing to bring a breach of fiduciary duty claim after benefits under an ERISA plan have been reduced or eliminated in cases where an employer-fiduciary provides false and misleading information about the benefits available under an ERISA plan. ERISA "was enacted, in part, to ensure that employees receive sufficient information about their rights under employee benefit plans to make well-informed employment and retirement decisions." *Harte v. Bethlehem Steel Corp.*, 214 F.3d 446, 451 (3d Cir. 2000) (citing *Jordan v. Fed. Express Corp.*, 116 F.3d 1005, 1012 (3d Cir. 1997)). It is of public importance to resolve this conflict by providing guidance as to whether an employer-fiduciary must correct false and misleading information about retirement benefits before detrimental reliance occurs or whether an employer fiduciary can fail to meaningfully convey information about its purported right to reduce or eliminate benefits

and then avoid liability by simply terminating all benefits in their entirety after individuals have made choices impacting their retirement to their detriment. This issue affects employers, employees, retirees and their beneficiaries, as well as future retirees and their beneficiaries. Further, denying standing to individuals who have relied upon false assurances about the security of lifetime benefits not only thwarts the purposes underlying ERISA, but also adds to the already over burdened Social Security and Medicare systems, by depriving individuals of pertinent information about their benefits at a time when they are most able to take alternative steps to provide for themselves.

In some cases, the First, Second, Fifth, Sixth, Seventh and Eleventh Circuit Courts of Appeals have applied or signaled acceptance of broad standing principles which support standing when an employer-fiduciary's malfeasance is tied to the loss of benefits and/or loss of participant status. *See Vartanian v. Monsanto Co.*, 14 F.3d 697, 702-03 (1st Cir. 1994); *Mullins v. Pfizer, Inc.*, 23 F.3d 663, 668 (2d Cir. 1994); *Christopher v. Mobil Oil Corp.*, 506 U.S. 820, 950 F.2d 1209, 1220-23 (5th Cir.), *cert. denied*, 121 L. Ed. 2d 35, 113 S. Ct. 68 (1992); *Swinney v. Gen. Motors Corp.*, 46 F.3d 512, 518-19 (6th Cir. 1995); *Panaras v. Liquid Carbonic Indus. Corp.*, 74 F.3d 786, 791 (7th Cir. 1996); *Willett v. Blue Cross & Blue Shield*, 953 F.2d 1335, 1342-3 (11th Cir. 1992). The Eighth Circuit implicitly adopted a more inclusive standing requirement under ERISA in *Howe v. Varity Corp.*, 36 F.3d 746 (8th Cir. 1994). *See Adamson v. Armco, Inc.*, 44 F.3d 650 (8th Cir. 1995). Similarly, the Ninth Circuit adopted a broader standing requirement under the whistleblower portion of ERISA. *McBride v. PLM Int'l, Inc.*, 179 F.3d 737, 746 (9th Cir.

1999). By contrast, the Fourth, Ninth, Tenth, and Eleventh Circuits have applied or signaled acceptance of more restrictive and narrow principles in determining standing under ERISA. *Stanton v. Gulf Oil Corp.*, 792 F.2d 432, 434-435 (4th Cir. 1986); *Kuntz v. Reese*, 785 F.2d 1410 (9th Cir. 1986); *Raymond v. Mobil Oil Corp.*, 983 F.2d 1528, 1535 (10th Cir. 1993); *Mitchell v. Mobil Oil Corp.*, 896 F.2d 463, 466 (10th Cir. 1990); *Sanson v. Gen. Motors Corp.*, 966 F.2d 618, 619 (11th Cir. 1992).

Those Courts of Appeals that have adopted broad standing principles have generally done so when an employer-fiduciary's malfeasance is tied to the loss of benefits and/or loss of participant status. *See Vartanian v. Monsanto Co.*, 14 F.3d 697, 702-03 (1st Cir. 1994); *Mullins v. Pfizer, Inc.*, 23 F.3d 663, 668 (2d Cir. 1994); *Christopher v. Mobil Oil Corp.*, 950 F.2d 1209, 1220-23 (5th Cir.), *cert. denied*, 506 U.S. 820, 121 L. Ed. 2d 35, 113 S. Ct. 68 (1992); *Swinney v. Gen. Motors Corp.*, 46 F.3d 512, 518-19 (6th Cir. 1995); *Panaras v. Liquid Carbonic Indus. Corp.*, 74 F.3d 786, 791 (7th Cir. 1996); *Willett v. Blue Cross & Blue Shield*, 953 F.2d 1335, 1342-3 (11th Cir. 1992). Under these cases, whether an individual has standing to bring a breach of fiduciary duty action under ERISA is not a straightforward two-pronged inquiry. "We are not convinced that *Firestone* can be read to reduce the standing question to a straightforward formula applicable in all cases," *Christopher v. Mobil Oil Corp.*, 950 F.2d 1209, 1221 (5th Cir. 1992), and an " . . . employer should not be able through its own malfeasance to defeat the employee's standing." *Christopher v. Mobil Oil Corp.*, 950 F.2d 1209, 1221 (5th Cir. 1992).

In the instant case, the Third Circuit claims to adopt a "but for" theory of standing which it would only apply if

the misrepresentations by Blue Cross caused plaintiffs to lose their status as participant or beneficiary. Petitioners respectfully submit that the Third Circuit has misconstrued the two-pronged formula of *Firestone* to preclude standing to any beneficiary or participant who is not receiving benefits under the plan, unless they meet a "but for" test under a heightened pleading requirement. *Firestone*, however, specifically includes colorable claim that an individual will prevail in a suit for benefits as a basis for standing. *Firestone*, 489 U.S. at 117.[1] The Third Circuit in this case did not properly apply this latter test.

ERISA creates a private right of action

> . . . by a participant or beneficiary . . . to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the plan.

29 U.S.C. § 1132(a)(1).

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[1] It is noteworthy that Justice Scalia concurred in part and concurred in the judgment of *Firestone*. Justice Scalia disagreed with the proposition that one could be a participant by virtue of having a "good argument" that he or she has vested benefits but turn out to be incorrect. *Firestone*, 489 U.S. at 119. Under Justice Scalia's analysis, those with "good argument[s]" that they have "some potential" to vested benefits would be treated as if they were participants for disclosure purposes because the penalties are so great that an incorrect exclusion of one with a "good argument" would be costly. If left without further analysis specific to the standing context, however, those with "good argument[s]" that they have vested benefits or those with "some potential" to vested benefits are being precluded in some Circuits from establishing that they would in fact prevail.

ERISA also authorizes a participant or beneficiary

> . . . to enjoin any act or practice which violates any provision of . . . [ERISA] . . . or the terms of the plan, or . . . to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of . . . [ERISA] . . . or the terms of the plan.

29 U.S.C. § 1132(a)(3).

Thus, to bring a breach of fiduciary duty claim under ERISA, one must be a participant or beneficiary. In *Firestone*, the Supreme Court interpreted the term "participant" under ERISA in the context of who is entitled to information and documents about an ERISA plan. Under *Firestone*, to satisfy the definition of participant (which in relevant part is the same as beneficiary), " . . . a claimant must have a colorable claim that (1) he or she will prevail in a suit for benefits, or that (2) eligibility requirements will be fulfilled in the future." *Firestone*, 489 U.S. at 118.

In the instant case, a retiree and a widow of a retiree were receiving health benefits under an ERISA plan. Those health benefits had been promised to them for the remainder of their lives. In 2001, Blue Cross terminated their health benefits under its purported reservation of its right to amend the Plan. However, prior to 2001, Blue Cross failed to meaningfully convey that it purported to retain the right to reduce or eliminate health benefits to retirees or their spouses. Prior to 2001, Blue Cross repeatedly promised and made assurances that retirees and their spouses would retain their health benefits for the remainder of their lives and amendments would only apply to future retirees, without any reference to the employer's purported reservation of the right to amend,

reduce or eliminate benefits. The retiree and widow seek reinstatement in the Plan as it existed prior to the 2001 amendments that terminated their benefits, or other appropriate equitable relief.

Both Ms. Mikulis and Mrs. Melley were owed a duty of full disclosure, honesty and fair dealing as either a participant or beneficiary *at the time* Blue Cross made the misrepresentations that they would be entitled to fully funded health benefits for the remainder of their lives. Both were receiving benefits *at the time* Blue Cross breached its promise of fully funded lifetime health benefits. Both reasonably, extensively, and foreseeably, relied upon the false promise of lifetime health benefits to their detriment when making decisions about their own retirement and health benefits. Blue Cross should not be permitted to shield itself from liability for its false promise of fully funded lifetime health benefits by simply terminating the health benefits entirely. Petitioners respectfully submit that *Firestone* does not mandate such an absurd result.

Furthermore, Ms. Mikulis satisfies the "but for" theory of standing. Blue Cross's repeated promise and assurance of fully funded lifetime health benefits, coupled with its specific incentive offered to employees to retire by April 1993 in order to retain the promised fully funded health benefit, without any reference to its purported reservation of the right to reduce or eliminate the health benefits even if they retired, deprived Ms. Mikulis and others similarly situated of the ability to make informed decisions about retirement and health benefits. By providing an incentive for retirement with fully funded lifetime health benefits without mention of Blue Cross's purported right to nonetheless reduce or eliminate those health

benefits, Blue Cross severely limited Ms. Mikulis and those similarly situated from having the information needed in order to make a rational decision about retirement. Sadly, Ms. Mikulis was induced to retire from a job she loved at the age of 62, after almost thirteen years of service with Blue Cross, in order to retain the post-retirement health benefits Blue Cross promised her. As a result of retiring when she did, however, she did not have the requisite fifteen years of services required to be eligible for even partially funded health insurance under the January 2001 amendment. The Third Circuit acknowledged that this met the "but for" standard, but erroneously imposed a heightened pleading requirement upon Ms. Mikulis in its failure to recognize her standing and claim. *Leuthner v. Blue Cross & Blue Shield of N.E. Pa.*, 454 F.3d 120, 130-131 (3d Cir. 2006) (Fisher, J., dissenting).

Respectfully submitted,

CLIFFORD A. RIEDERS, ESQUIRE
(*Counsel of Record*)

Attorney for Petitioners
Elizabeth Melley and Jean Mikulis

454 F.3d 120

Frank W. LEUTHNER; William Reasner, and All Others Similarly Situated
Elizabeth Melley; Jean Mikulis, Intervenor-Plaintiffs in District Court

v.

BLUE CROSS AND BLUE SHIELD OF NORTHEASTERN PENNSYLVANIA
Elizabeth Melley and Jean Mikulis, Appellants.

No. 04-4389.

United States Court of Appeals,
Third Circuit.

Argued Sept. 22, 2005.

Opinion filed July 10, 2006.

Clifford A. Rieders, Esquire, (Argued), Rieders, Teavis, Humphrey, Harris, Wates & Waffenschmidt, Williamsport, PA, for Appellant.

John F. Schultz, Esquire, (Argued), Kristofor T. Henning, Esquire, Morgan, Lewis & Bockius, Philadelphia, PA, for Appellees.

Before McKEE, FISHER and ROTH,* Circuit Judges.

OPINION

ROTH, Circuit Judge.

If the beneficiary of an ERISA plan has lost her status as a beneficiary, due to what she claims is the plan

* Judge Roth assumed senior status on May 31, 2006.

administrator's breach of fiduciary duty, does she then have standing to sue the administrator under ERISA § 502(a), 29 U.S.C. § 1132(a)? Appellant Jean Mikulis retired early from Blue Cross, relying on what she claims was a promise from Blue Cross to provide her with 100% lifetime health benefits. Appellant Elizabeth Melley is the widow of a Blue Cross retiree. Both women lost their lifetime health benefits when the Blue Cross Plan was retroactively changed on January 1, 2001. After their benefits had been terminated, they intervened in a class action that had been brought by other Plan participants and beneficiaries to challenge the retroactive changes. The District Court dismissed Mikulis and Melley's suits under FED.R.CIV.P. 12(b)(6) for lack of statutory standing. Although appellants may have made retirement decisions based on a belief that their retirement medical benefits would continue for their lifetimes, we agree with the District Court's determination that they do not have statutory standing to bring this action. We will, therefore, affirm.

I. Background

Blue Cross Blue Shield of Northeastern Pennsylvania (Blue Cross) administers the Blue Cross of Northeastern Pennsylvania Retiree Health Insurance Plan (the Plan), a welfare benefits plan for Blue Cross retirees. The Plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001, *et seq.* Blue Cross is a Plan fiduciary under 29 U.S.C. § 1002(21)(A).[1] Originally,

[1] Congress defines a plan fiduciary as a person: (i) [who] exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control

(Continued on following page)

the Plan provided Blue Cross retirees with 100% lifetime health insurance coverage. Blue Cross altered the Plan in 1993, and then again in 1999 and 2001. Starting in 1993, the Plan's coverage changed to a formula that provided a percentage of the cost of the health care plan, based on the number of years of service that an employee had on retirement. The formula required a minimum of 10 years of service. The formula was changed in 1999 to require a minimum of 15 years of service. The 1993 and 1999 changes were applied prospectively to new retirees; the benefits of former retirees were not changed. On January 1, 2001, Blue Cross again amended the Plan (1) to provide for a graduated dollar contribution toward health insurance coverage for retirees with at least 15 years of service and (2) to eliminate coverage for surviving spouses of retirees. Blue Cross applied the 2001 Plan Amendment retroactively to all retirees.

Retired Blue Cross employees have brought a class action against Blue Cross for breach of fiduciary duty stemming from various changes made in the Plan's coverage.[2] Elizabeth Melley and Jean Mikulis are intervenors in the action. Mikulis was an employee of Blue Cross for almost 13 years. She retired at age 62 on February 27, 1993, after being notified by Blue Cross that, unless she retired by April 1, 1993, her future retirement health

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respecting management or disposition of its assets, (ii) [who] renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) [who] has any discretionary authority or discretionary responsibility in the administration of such plan.

29 U.S.C. § 1002(21)(A).

[2] The District Court has denied class certification.

benefits would no longer be guaranteed at 100% lifetime but would be subject to a percentage formula based on years of employment. As a result of early retirement, Mikulis received a smaller pension from Blue Cross and reduced Social Security benefits. Mikulis received 100% benefits under the Plan until January 1, 2001, when she ceased to be eligible for any benefits under the amended Plan. She claims to have relied on having 100% lifetime health coverage in her savings and spending decisions.

Melley is the widow of a Blue Cross retiree. The record does not indicate when Melley's late husband retired from Blue Cross, what his age was at retirement, or if he had other employment thereafter. Melley received benefits under the Plan until January 1, 2001, when she ceased to be eligible for any benefits under the amended Plan.

Mikulis and Melley claim that Blue Cross knowingly made various material misrepresentations and omissions about Plan benefits and amendments. In particular, they maintain that they had no notice before the 1993 Plan amendment that Blue Cross could alter the Plan. They also allege that Blue Cross's pre-2001 practice of applying Plan changes only prospectively led them to believe that any future changes would be prospective. They further claim that they relied upon Blue Cross's misrepresentations and omissions to their detriment. Mikulis contends that, but for Blue Cross's misrepresentations and omissions, she would not have taken early retirement. Melley alleges that her late husband made retirement and insurance decisions based upon the promise of continuing lifetime health benefits for his spouse, even in the event of his death.

Mikulis and Melley brought an action under ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), in which they allege that Blue Cross breached its fiduciary duties under ERISA § 404(a), 29 U.S.C. § 1104(a) by amending the plan in 2001[3] and by failing to disseminate accurate information about the terms of retiree medical benefits under the Plan. They are seeking either reinstatement in the Plan as it existed prior to the 2001 amendments, comparable coverage, or its monetary equivalent.

Blue Cross moved to dismiss pursuant to FED. R. CIV. P. 12(b)(1), 12(b)(6) and/or 56. The District Court construed the motion as a motion to dismiss under Rule 12(b)(6) because the parties' submissions did not include matters outside of the pleadings. The District Court found that Mikulis and Melley did not have standing because they were neither Plan participants nor beneficiaries at the time they commenced their suit. Accordingly, the District Court dismissed both complaints for lack of standing. The District Court certified its judgment as final under FED. R. CIV. P. 54(b). This appeal followed.

II. Jurisdiction and Standard of Review

We undertake a plenary review of the grant of a motion to dismiss, *Jordan v. Fox, Rothschild, O'Brien & Frankel,* 20 F.3d 1250 (3d Cir.1994), including questions of standing. *Miller v. Rite Aid Corp.,* 334 F.3d 335, 340 (3d Cir.2003). When considering an appeal from a dismissal pursuant to Rule 12(b)(6), we accept as true all well-pled

[3] Mikulis and Melley no longer contend that the amendment of the plan constituted a breach of fiduciary duty.

factual allegations. *Morse v. Lower Merion Sch. Dist.*, 132 F.3d 902, 906 (3d Cir.1997).

III. Discussion

ERISA's statutory standing requirements provide in § 502(a)(1) and (3) that a civil action may only be brought:

> (1) by a participant or beneficiary . . .
>
> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan. . . .
>
> (3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan.

29 U.S.C. § 1132(a)(1), (a)(3).

The terms "participant" and "beneficiary" are defined in ERISA § 3(7)-(8):

> (7) The term "participant" means any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.
>
> (8) The term "beneficiary" means a person designated by a participant, or by the terms of an

> employee benefit plan, who is or may become entitled to a benefit thereunder.

29 U.S.C. § 1002(7)-(8).

The Supreme Court has held that:

> the term "participant" is naturally read to mean either "employees in, or reasonably expected to be in, currently covered employment," or former employees who "have . . . a reasonable expectation of returning to covered employment" or who have "a colorable claim" to vested benefits. In order to establish that he or she "may become eligible" for benefits, a claimant must have a colorable claim that (1) he or she will prevail in a suit for benefits, or that (2) eligibility requirements will be fulfilled in the future. "This view attributes conventional meanings to the statutory language since all employees in covered employment and former employees with a colorable claim to vested benefits 'may become eligible.'"

Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 118, 109 S.Ct. 948, 103 L.Ed.2d 80 (1989) (internal citations omitted).

Thus, to bring a civil action under ERISA, Melley and Mikulis must have a colorable claim to Plan benefits as the result of their suit. We have interpreted the colorable claim requirement as a lower burden of persuasion than showing likelihood of success on the merits. *Daniels v. Thomas & Betts Corp.,* 263 F.3d 66, 78-79 (3d Cir.2001).

Mikulis and Melley have raised four arguments as to why they fall within the definition of participant or beneficiary and have statutory standing. First, they maintain that they have standing because they are within

the zone of interest protected by ERISA. Second, they claim that they have standing because they have a colorable claim to receive Plan benefits in the future as part of an equitable remedy. Third, they argue that they have standing because they formerly received Plan benefits and they detrimentally relied on Blue Cross's misrepresentations. Finally, Mikulis contends that she has standing because, but for Blue Cross's misrepresentations and omissions, she would not have retired when she did.

For the reasons stated below, we reject these arguments.

1. Zone of Interest

To bring a civil action under ERISA, a plaintiff must have constitutional, prudential, and statutory standing. There is no question of Mikulis and Melley's constitutional standing in this case. They argue, however, that they have prudential standing because they are within the "zone of interest" that ERISA was created to protect and that prudential standing gives them statutory standing.

Whether a party has prudential standing depends on whether "a plaintiff's grievance . . . arguably fall[s] within the zone of interest protected or regulated by the statutory provision or constitutional guarantee invoked in the suit." *Bennett v. Spear,* 520 U.S. 154, 162, 117 S.Ct. 1154, 137 L.Ed.2d 281 (1997). As a general matter, we have found that statutory standing requirements can eliminate prudential standing restrictions but are presumed not to:

> Because prudential standing doctrine is judge-made and not the product of constitutional restraints on the power of the federal courts to hear claims, Congress can eliminate prudential

> restrictions on standing if it so desires. As a matter of statutory interpretation, however, Congress is presumed to incorporate background prudential standing principles, unless the statute expressly negates them.

Conte Bros. Auto., Inc. v. Quaker State-Slick 50, Inc., 165 F.3d 221, 227 (3d Cir.1998). "The first inquiry, then, is whether Congress expressly negated [the] prudential standing doctrine in passing the [statute at issue]." *Id.*

We extensively addressed the interplay of prudential and statutory standing in ERISA cases in *Rite Aid.* We remarked there that in past decisions we had stated that "[f]ar from abrogating the prudential standing doctrine . . . ERISA § 502(a)(1) . . . *restricts* civil actions brought against a plan administrator to actions brought by a 'participant or beneficiary.'" 334 F.3d at 340 (quoting *Saporito v. Combustion Eng'g Inc.,* 843 F.2d 666, 670-71 (3d Cir.1988), *vacated on other grounds by Combustion Eng'g, Inc. v. Saporito,* 489 U.S. 1049, 109 S.Ct. 1306, 103 L.Ed.2d 576 (1989)). In other words, the language of § 502(a)(1) sets forth the standing requirements to bring such an action – both prudential and statutory standing:

> In that sense, the "zone of interest" inquiry in the prudential standing analysis for § 502(a)(1) claims is inextricably tied to the question of whether a plaintiff can meet the definitions of either a "participant" or "beneficiary".

Rite Aid, 334 F.3d at 341.

Rite Aid opened the door to some confusion, however, by citing in support of the above quotation on "zone of interest" the case of *Vartanian v. Monsanto Co.,* 14 F.3d

697 (1st Cir.1994). In the citation, the *Rite Aid* Court quoted *Vartanian* parenthetically:

> "In determining who is a 'participant,' for purposes of standing, the definition found in 29 U.S.C. § 1002(7) must be read in the context of traditional concepts of standing. . . . *The ultimate question is whether the plaintiff is within the zone of interest ERISA was intended to protect.*"

334 F.3d at 341 (quoting *Vartanian,* 14 F.3d at 701) (emphasis original to *Vartanian).*

Mikulis and Melley have focused on this citation and quotation of *Vartanian* to interpret *Rite Aid* to support the proposition that the analysis for *statutory* standing under ERISA is actually the *prudential* standing "zone of interest" analysis.

This interpretation is not correct. When we stated in *Rite Aid* that "the 'zone of interest' inquiry in the prudential standing analysis for § 502(a)(1) claims is inextricably tied to whether a plaintiff can meet the definitions of either 'participant' or 'beneficiary'," 334 F.3d at 341, we meant that statutory standing requirements in ERISA § 502(a)(1) were essentially a codification of ERISA's "zone of interest" – we did not mean the inverse, *i.e.,* that prudential standing suffices for statutory standing. Indeed, it would make little sense for Congress to have enacted ERISA § 502(a)(1) to define who may bring suit against a plan administrator if standing to sue were to be determined by the traditional "zone of interest" prudential standing test.

Moreover, despite the citation to *Vartanian,* we did not undertake a "zone of interest" analysis in *Rite Aid.* Instead, we focused solely on whether the plaintiff met the

ERISA § 3(7) definition of "participant." This focus is consistent with the conclusion that ERISA's statutory standing requirements are a codification of the "zone of interest" analysis. Mikulis and Melley's "zone of interest" argument does not prevail.

2. Colorable Claim to a Remedy Under ERISA

ERISA §§ 3(7) and 3(8) define participants and beneficiaries as those "who [are] or may become eligible to receive a benefit of any type from an employee benefit plan. . . ." Tracking this language, Mikulis and Melley's second argument is that they have standing because they are Plan participants/beneficiaries and they qualify as participants/beneficiaries because they have a colorable claim to receive Plan benefits in the future via equitable relief ordering the restoration of the Plan to its pre-January 1, 2001, status or enjoining the retroactive application of the January 1, 2001, Amendment.

Blue Cross contends that Mikulis and Melley waived this issue by not raising it before the District Court. We do not agree. We find sufficient reference before the District Court by Mikulis and Melley to "a colorable claim to vested benefits" to convince us that this argument was not waived.

Turning to the merits of the colorable claim to benefits argument, Blue Cross made four objections to it. First, Blue Cross contends that Mikulis and Melley have not asserted any claim for reinstatement in the Plan under ERISA § 502(a)(1)(B) but have merely requested monetary damages. Blue Cross is incorrect. Mikulis and Melley's joint Amended Class Action Complaint specifically requested that the Court "order the Defendant to reinstitute

the Plan as it was in existence prior to the change complained of, and/or enjoin Defendant from implementing the revised Plan", not to mention award "such other legal and equitable relief as the Court may deem just and necessary." Mikulis's Second Amended Complaint only requests "Any other legal and equitable relief as the Court may deem just and necessary." Although this is boilerplate, it tracks the language of ERISA § 502(a)(3)(B), 29 U.S.C. § 1132(a)(3)(B), which provides for participants and beneficiaries to bring suit "to obtain other appropriate equitable relief (i) to redress [ERISA violations] or (ii) to enforce any provisions of this subchapter or the terms of the plan".

Second, Blue Cross argues that under our decision in *Daniels,* 263 F.3d at 78, equitable relief is not a plan benefit. Thus, the right to equitable relief cannot give standing. This is not a correct reading of *Daniels. Daniels* merely determined that monetary damages are not plan benefits. It did not address the question of whether equitable relief could constitute a benefit under a plan. Here, Mikulis and Melley are requesting equitable relief including reinstatement of the Plan "as it was in existence prior to the changes complained of." The *sine qua non* of benefits of the Plan is to be covered by the Plan.

Third, Blue Cross remonstrates that Mikulis and Melley cannot have standing as a result of possible equitable relief because standing must exist at the time a suit is commenced, not at the time of judgment. For constitutional and prudential standing it is well established that standing must exist at the time the suit is commenced and throughout the suit. *See, e.g., Friends of the Earth v. Laidlaw Envtl. Servs.,* 528 U.S. 167, 189, 120 S.Ct. 693, 145 L.Ed.2d 610 (2000); *Lujan v. Defenders of Wildlife,* 504

U.S. 555, 561, 571 n. 5, 112 S.Ct. 2130, 119 L.Ed.2d 351 (1992); *PIRG v. Magnesium Elektron, Inc.,* 123 F.3d 111, 117 (3d Cir.1997). We have not addressed this issue in regard to statutory standing; moreover, because a decision on this issue is not necessary for the outcome of this case, we do not express an opinion on it now.[4]

Fourth, Blue Cross maintains that because the amendment of ERISA plans is not a fiduciary act, equitable relief is not available. ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), authorizes equitable relief only for violations of ERISA's provisions. The amendment of an ERISA plan is not a fiduciary act governed by ERISA. *Lockheed Corp. v. Spink,* 517 U.S. 882, 890, 116 S.Ct. 1783, 135 L.Ed.2d 153 (1996); *Walling v. Brady,* 125 F.3d 114, 120 (3d Cir.1997). Therefore, as the District Court correctly noted, Blue Cross did not violate ERISA by amending the Plan.

Mikulis and Melley, however, alleged breaches of fiduciary duty that included not only the amendment of the Plan, but also misrepresentations about future plan benefits and coverage. Unlike the amendment of the Plan, the provision of information about Plan benefits and coverage is a fiduciary act. *Adams v. Freedom Forge Corp.,* 204 F.3d 475, 492 (3d Cir.2000). Therefore, "[a]n employee may recover for a breach of fiduciary duty if he or she proves that an employer, acting as a fiduciary, made a

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[4] We note, however, that Blue Cross has wrongly conflated the inquiry for standing with an inquiry on the merits. The issue is not whether litigants are entitled to injunctive relief, but merely whether they have a colorable claim to it. If they have a colorable claim to receiving injunctive relief that would make them Plan beneficiaries, then they fall within ERISA §§ 3(7)-(8) definitions of participant and beneficiary, 29 U.S.C. § 1002(7)-(8), and have standing under ERISA § 502(a)(1), 29 U.S.C. § 1132(a)(1).

misrepresentation that would confuse a reasonable beneficiary about his or her benefits, and the beneficiary acted thereupon to his or her detriment." In re *Unisys Corp. Retiree Med. Benefit "ERISA" Litig.*, 242 F.3d 497, 505 (3d Cir.2001). If Mikulis and Melley raised a colorable claim of such a breach and detrimental reliance, then they would have standing because they would have a colorable claim to be eligible for equitable relief under § 502(a)(3).

As the District Court noted, however, Blue Cross' alleged misrepresentations did not divest Melley of her status as a plan beneficiary. It was the January 1, 2001, amendment of the Plan that did so. Melley's status was determined by her situation as surviving spouse of a retired Blue Cross employee. The alleged misrepresentations had no effect on that status nor was Melley in a position to make any changes to her status based on them. Her medical benefits were not a vested benefit, and the Plan contained language, inserted in the 1993 amendment, that it could be changed and that health benefits could be discontinued at any time. Thus, we find no basis to conclude that Melley's status as a beneficiary was affected by the alleged misrepresentations.

Mikulis is in the same situation as Melley in regard to the alleged misrepresentations made since the time of her retirement. Mikulis was not in a position to change her status of retired employee. Mikulis has, however, raised a related argument – "but for" Blue Cross's misrepresentations she would have retired later and would currently be a Plan participant.

In *Saporito v. Combustion Engineering, Inc.*, we adopted a "but for" theory of ERISA standing, holding that "but for the selective divulgence of information [by the

plan fiduciary], [appellants] would have been members [of the plan], and, for the purposes of standing to bring an action under ERISA, should be considered as such." 843 F.2d at 672. The *Saporito* plaintiffs, however, were not and had not been members of the plan in question. Their "but for" claim was one to make them members of a plan concerning which they claimed not to have been informed. *Saporito,* however, was decided before the Supreme Court's decision in *Firestone.* The Supreme Court vacated our judgment in *Saporito* without comment and remanded it in light of its decision earlier that week in *Firestone. Combustion Eng'g, Inc. v. Saporito,* 489 U.S. 1049, 109 S.Ct. 1306, 103 L.Ed.2d 576 (1989). Since the Supreme Court's ruling in *Firestone,* we have not had occasion to rule on the issue of whether a claimant, who is a former plan participant, has standing when it is the alleged breach of fiduciary duty that has caused the claimant to lose status as a plan participant.

ERISA's legislative history indicates that Congress intended the federal courts to construe the statutory standing requirements broadly in order to facilitate enforcement of its remedial provisions:

> The enforcement provisions have been designed specifically to provide both the Secretary [of Labor] and participants and beneficiaries with broad remedies for redressing or preventing violations of the [Act]. . . . The intent of the Committee is to provide the full range of legal and equitable remedies available in both state and federal courts and to remove jurisdictional and procedural obstacles which in the past appear to have hampered effective enforcement of fiduciary responsibilities under state law or recovery of benefits due to participants.

S. REP. NO. 127, 93d Cong., 2d Sess., 3 (1974), reprinted in 1974 U.S.C.C.A.N. 4639, 4871. Refusing to allow for "but for" standing would frustrate Congress's intention to remove jurisdictional and procedural obstacles to ERISA claims.

The majority of circuits that have addressed whether there is a "but for" exception for ERISA standing have adopted it. In *Christopher v. Mobil Oil Corp.,* 950 F.2d at 1221, the Fifth Circuit concluded that "it would seem more logical to say that but for the employer's conduct alleged to be in violation of ERISA, the employee *would* be a current employee with a reasonable expectation of receiving benefits, and the employer should not be able through its own malfeasance to defeat the employee's standing." Similarly, in *McBride v. PLM Int'l, Inc.,* 179 F.3d 737, 743 (9th Cir.1999), the Ninth Circuit held that "[i]f an employee is a participant at the time of the alleged ERISA violation and alleges that he was discharged or discriminated against because of the protected whistleblowing activities, we hold that such an employee has standing to sue under ERISA." *Accord, Swinney,* 46 F.3d at 518-519; *Mullins v. Pfizer,* 23 F.3d 663, 668 (2nd Cir.1994); *Vartanian,* 14 F.3d at 702. *But see Raymond v. Mobil Oil Corp.,* 983 F.2d 1528, 1536 (10th Cir.1993); *Stanton v. Gulf Oil Corp.,* 792 F.2d 432 (4th Cir.1986) (rejecting "but for" theory of ERISA standing).

A plan administrator's alleged ERISA violation should not be the means by which the plan is able to insulate itself from suits arising from the alleged violation. We will not read ERISA so myopically. As the Sixth Circuit observed, "ERISA should not be construed to permit the fiduciary to circumvent his ERISA-imposed fiduciary duty in this manner." *Swinney,* 46 F.3d at 518-519. Therefore, in

the proper case, we may find that a plaintiff has statutory standing if the plaintiff can in good faith plead that she was an ERISA plan participant or beneficiary and that she still would be but for the alleged malfeasance of a plan fiduciary.

Turning to the case before us, in reviewing Mikulis's allegation that she would not have retired when she did had Blue Cross not made various misrepresentations and omissions, we must keep in mind that Mikulis retired on February 27, 1993, and any reliance on statements by Blue Cross that induced her to retire must have occurred before that time. More importantly, for Mikulis to prevail, her reliance must have been on "a material misrepresentation that would confuse a reasonable beneficiary about his or her benefits, and the beneficiary acted thereupon to his or her detriment." *Unisys,* 242 F.3d at 505.

Mikulis was instructed by the District Court in its Memorandum and Order of May 7, 2004, that in her Second Amended Complaint, she must set forth the specific actions she took or refrained from taking in reliance on Blue Cross's alleged misrepresentations and identify how she was harmed by the asserted action or forbearance. She has not done so except in generalities, as she did in her earlier complaint. Nor has she alleged how much longer she would have worked "but for" the alleged misrepresentations. In 1993, the 15 year cut-off of benefits, instituted in 2001, was not mentioned at all. There is no basis to conclude from the allegations in the complaint that, even if she had worked longer, she would still have qualified for benefits after the 2001 amendment.

In addition, Mikulis has not alleged that the statements made by Blue Cross prior to the 1993 amendment

were false at the time that they were made. Without such an allegation, there is no ground to assert a breach of fiduciary duty. *Id.* A representation is not a misrepresentation if it is an accurate reflection of the plan administrator's intent when the statement was made.

We conclude therefore that Mikulis's "but for" claim is not a colorable claim for benefits and thus is insufficient to give her standing under *Firestone*.

IV. Conclusion

For the reasons discussed above, we will affirm the District Court's dismissal of Melley and Mikulis's claims.

FISHER, Circuit Judge, concurring in part and dissenting in part.

The majority concludes that neither of the two intervenor-plaintiffs in this case has standing to pursue a claim for breach of fiduciary duty under § 502(a) of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1132(a). While I agree that Elizabeth Melley cannot maintain such a claim, because she was never an employee of Blue Cross and could not have relied on the company's purported misrepresentations, I believe that Jean Mikulis, as a former Blue Cross employee, has demonstrated a potential right to relief and should be allowed to proceed with her case. I respectfully dissent from the decision to affirm the dismissal of her claim.

The majority acknowledges that, "in a proper case, we may find that a plaintiff has statutory standing if the plaintiff can in good faith plead that she was an ERISA plan participant or beneficiary and that she still would be but for the alleged malfeasance of a plan fiduciary." *Supra*

p. 129 (majority op.). I submit that this is a "proper case." According to the complaint, Mikulis was urged by Blue Cross in 1992, after nearly thirteen years of service, to accept early retirement. She acquiesced after being assured by the company that she would receive full health insurance benefits upon retirement and that those benefits would continue "without amendment" for her lifetime. (A.144, 146, 158.) This promise, of guaranteed lifetime benefits without the possibility of change, is plainly contrary to plan provisions reserving the administrator's right to amend. As a result of her reliance on this misrepresentation, Mikulis was denied benefits when the plan was amended in 2001 to limit coverage to only those retirees who had worked at the company for more than fifteen years. (A.168, 173.) Had Mikulis known in 1992 that her benefits were subject to change, she presumably would have remained in the company's employ, possibly exceeding the fifteen-year threshold for coverage under the current plan. (A.144-46, 158.) In other words, "but for" the alleged misrepresentation by Blue Cross, Mikulis might still be a participant in the plan. *Cf. supra* p. 123 (majority op.) ("Mikulis contends that, but for Blue Cross's misrepresentations and omissions, she would not have taken early retirement."). She thus has standing to assert a claim for breach of fiduciary duty. *See, e.g., Daniels v. Thomas & Betts Corp.,* 263 F.3d 66, 73-76, 78-79 (3d Cir.2001).

The deficiencies cited by my colleagues are not grounds for dismissal. They complain that (1) Mikulis has set forth only "generalities" regarding the factual predicate of her claim, (2) she has not specified "how much longer she would have worked 'but for' the alleged misrepresentations," and (3) she "has not alleged that the

statements made by Blue Cross prior to the 1993 amendment were false at the time that they were made." *Supra* p. 129 (majority op.). The third point seems to ignore Mikulis's allegation that the company promised her in 1992 that the health insurance benefits offered under the then-existing plan would not be subject to change, a representation that is clearly contrary to the plan's terms. (A.142-44, 168, 173.)

The other two points are similarly invalid, as they seem to impose upon Mikulis a "heightened pleading standard," demanding that she set forth the facts underlying her claim with particularity. This approach has been soundly rejected by the Supreme Court as inconsistent with the liberal pleading system embodied in the Federal Rules of Civil Procedure, which require only that the complaint provide "fair notice" of the proposed cause of action, allowing the court to assess whether relief is potentially available and permitting the parties to engage in meaningful discovery. *Swierkiewicz v. Sorema N.A.*, 534 U.S. 506, 514, 122 S.Ct. 992, 152 L.Ed.2d 1 (2002); *Leatherman v. Tarrant County Narcotics Intelligence & Coordination Unit*, 507 U.S. 163, 168, 113 S.Ct. 1160, 122 L.Ed.2d 517 (1993); *see also* 5 Charles Alan Wright & Arthur R. Miller, *Federal Practice and Procedure* §§ 1202, 1215 (3d ed.2004). The complaint in this case satisfies this minimal burden. *Cf. Conley v. Gibson*, 355 U.S. 41, 45-46, 78 S.Ct. 99, 2 L.Ed.2d 80 (1957) ("[A] complaint should not be dismissed for failure to state a claim unless it appears beyond doubt that the plaintiff can prove no set of facts in support of his claim which would entitle him to relief."). The concerns raised by my colleagues reflect possible deficiencies in the proof, not defects in the pleadings, and they should be addressed through discovery and summary

judgment, not dismissal of the complaint. *See, e.g., Swierkiewicz,* 534 U.S. at 514, 122 S.Ct. 992.

I would reverse the order of the District Court dismissing the complaint as to Mikulis and remand for further proceedings.

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 04-4389

FRANK W. LEUTHNER;
WILLIAM REASNER,
AND ALL OTHERS SIMILARLY SITUATED

ELIZABETH MELLEY; JEAN MIKULIS,

Intervenor-Plaintiffs in District Court

v.

BLUE CROSS AND BLUE SHIELD OF
NORTHEASTERN PENNSYLVANIA

Elizabeth Melley and Jean Mikulis,

Appellants

Appeal from the United States District Court
for the Middle District of Pennsylvania
(D.C. Civil Action No. 02-CV-01709)
District Judge: Honorable John E. Jones, III

Argued on September 22, 2005

Before: MCKEE, FISHER and ROTH,* Circuit Judges

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* Judge Roth assumed senior status on May 31, 2006.

JUDGMENT

This case came on to be heard on the record before the United States District Court for the Middle District of Pennsylvania and was argued on September 22, 2005.

On consideration whereof,

IT IS ORDERED AND ADJUDGED by this Court that the judgment of the District Court dated November 12, 2004, **be and the same is hereby affirmed. Costs taxed against appellants.**

All of the above in accordance with the opinion of this Court.

ATTEST:

/s/ Marcia M. Waldron
Clerk

Dated: July 10, 2006

Certified as a true copy and issued in lieu of a formal mandate on 8/7/06

Teste: Marcia M. Waldron
Clerk, U.S. Court of Appeals for the Third Circuit

270 F.Supp.2d 584

Frank W. LEUTHNER, William Reasner, and All Others Similarly Situated, Plaintiffs,

v.

BLUE CROSS AND BLUE SHIELD OF NORTHEASTERN PENNSYLVANIA, Defendant.

No. 4:CV-02-1709.

United States District Court, M.D. Pennsylvania.

July 11, 2003.

Kristofor T. Henning, Mary Catherine Roper, John F. Schultz, Drinker, Biddle & Reath, LLP, Philadelphia, PA, for Defendants.

Rodney L. Knier, Rieders, Travis Law Firm, Clifford A. Rieders, Rieders, Travis, Humphrey, Harris, Waters & Waffenschmidt, Williamsport, PA, for Plaintiffs.

MEMORANDUM AND ORDER

JONES, District Judge.

PROCEDURAL HISTORY:

The plaintiffs, Frank W. Leuthner ("Leuthner") and William Reasner ("Reasner") (together, "Plaintiffs"), initiated this action by filing a class action complaint on September 26, 2002, pursuant to the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq.* and Pennsylvania state law.

This suit was brought by Plaintiffs in their capacity as retired salaried employees of the defendant, Blue Cross and Blue Shield of Northeastern Pennsylvania ("Blue Cross" or "Defendant"), and as participants in the Blue Cross of Northeastern Pennsylvania Retiree Health Insurance Plan ("the Plan"), an employee welfare plan sponsored and administered by Blue Cross which is subject to ERISA. Plaintiffs' Complaint is set forth in three counts. All counts arise from an amendment to the Plan which went into effect on January 1, 2001, and resulted in a reduction of health care benefits to Plan participants. In Count I, Plaintiffs assert that the implementation of the amended Plan was a breach of Blue Cross' fiduciary duty to the Plan's participants and beneficiaries. (*See* Complaint at ¶¶ 46-48). In Count II, Plaintiffs assert a claim of detrimental reliance and estoppel based upon allegations that Blue Cross had misrepresented to Plaintiffs that they would receive lifelong fully funded health insurance coverage under the Plan. (*See* Complaint at ¶¶ 51-54). Finally, in Count III, Plaintiffs allege that Defendant's course of conduct constitutes bad faith under the Pennsylvania Bad Faith Statute, 42 Pa.C.S.A. § 8371.

On July 9, 2003, this Court issued an order denying Plaintiffs' Motion for Class Certification.

Currently pending before the Court is Defendant's Motion to Dismiss, filed on December 6, 2002, and Plaintiffs' Cross Motion Pursuant to Rule 56(f), filed on July 7, 2003.

Subsequent to conducting a preliminary review of the Motion to Dismiss and the briefs filed by the parties in connection with it, we issued an order on June 13, 2003 providing the parties with notice that pursuant to Federal

Rule of Civil Procedure 12(b) we would convert the Motion to Dismiss into a motion for summary judgment. *See* Fed.R.Civ.P. 12(b) ("If matters outside the pleading are presented to and are not excluded by the court, the motion shall be treated as a motion for summary judgement and disposed of as provide din [sic] Rule 56, and all parties shall be given reasonable opportunity to present all material made pertinent by such a motion by Rule 56"). The June 13, 2003 Order granted the parties ten days within which to submit additional materials for the Court's consideration in disposing of the Motion . . . accordance with the standards applicable for motions for summary judgment brought pursuant to Federal Rule of Civil Procedure 56.

This matter is now ripe for disposition. For the reasons that follow, we will grant the Motion for Summary Judgment and deny the Cross Motion Pursuant to Rule 56(f).

STANDARD OF REVIEW:

Summary judgment is appropriate if "there is no genuine issue as to any material fact and . . . the moving party is entitled to judgment as a matter of law." F.R.C.P. 56(c); *see also Turner v. Schering-Plough Corp.,* 901 F.2d 335, 340 (3d Cir.1990). The party moving for summary judgment bears the burden of showing "there is no genuine issue for trial." *Young v. Quinlan,* 960 F.2d 351, 357 (3d Cir.1992). Summary judgment should not be granted when there is a disagreement about the facts or the proper inferences which a fact finder could draw from them. *See Peterson v. Lehigh Valley Dist. Council,* 676 F.2d 81, 84 (3d Cir.1982).

Initially, the moving party has a burden of demonstrating the absence of a genuine issue of material fact. *See Celotex Corporation v. Catrett,* 477 U.S. 317, 323, 106 S.Ct. 2548, 91 L.Ed.2d 265 (1986). This may be met by the moving party pointing out to the court that there is an absence of evidence to support an essential element as to which the non-moving party will bear the burden of proof at trial. *See id.* at 325, 106 S.Ct. 2548.

Rule 56 provides that, where such a motion is made and properly supported, the non-moving party must then show by affidavits, pleadings, depositions, answers to interrogatories, and admissions on file, that there is a genuine issue for trial. *See* Fed.R.Civ.P. 56(e). The United States Supreme Court has commented that this requirement is tantamount to the non-moving party making a sufficient showing as to the essential elements of their case that a reasonable jury could find in its favor. *See Celotex Corporation v. Catrett,* 477 U.S. 317, 322-23, 106 S.Ct. 2548, 91 L.Ed.2d 265 (1986).

It is important to note that "the non-moving party cannot rely upon conclusory allegations in its pleadings or in memoranda and briefs to establish a genuine issue of material fact." *Pastore v. Bell Tel. Co. of Pa.,* 24 F.3d 508, 511 (3d Cir.1994) (citation omitted). However, all inferences "should be drawn in the light most favorable to the non-moving party, and where the non-moving party's evidence contradicts the movant's, then the non-movant's must be taken as true." *Big Apple BMW, Inc. v. BMW of North America, Inc.,* 974 F.2d 1358, 1363 (3d Cir.1992), *cert. denied,* 507 U.S. 912, 113 S.Ct. 1262, 122 L.Ed.2d 659 (1993) (citations omitted).

Still, "the mere existence of *some* alleged factual dispute between the parties will not defeat an otherwise properly supported motion for summary judgment; the requirement is that there be no *genuine* issue of *material* fact." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 247-48, 106 S.Ct. 2505, 91 L.Ed.2d 202 (1986). "As to materiality, the substantive law will identify which facts are material." *Id.* at 248, 106 S.Ct. 2505. A dispute is considered to be genuine only if "the evidence is such that a reasonable jury could return a verdict for the nonmoving party." *Id.*

RELEVANT FACTUAL BACKGROUND:

Some of the facts in this matter are highly disputed. We will, where necessary, view the facts and all inferences to be drawn from them in the light most favorable to the nonmoving party in our analysis of each motion.

As noted previously, Plaintiffs are participants in the Plan, which is sponsored and administered by Blue Cross.

Prior to the January 1, 2001 amendment to the Plan, Blue Cross contributed a percentage of the cost of medical benefits coverage available to its retirees and their surviving spouses based upon the retirees' years of service. Effective January 1, 2001, the Plan was altered such that coverage to surviving spouses was eliminated and eligible retirees received a fixed dollar amount from Blue Cross each month, calculated based upon the retiree's years of service at Blue Cross, to be utilized for the purpose of purchasing health care insurance coverage.

At the time of their retirement, Plaintiffs had both accumulated over twenty-five years of service with Blue

Cross. In accordance with the aforementioned contractual schemes, prior to January 1, 2001, Blue Cross paid the entire cost of Plaintiffs' post-retirement medical insurance. However, subsequent to the January 1, 2001 amendment, Blue Cross paid, and apparently continues to pay, each Plaintiff $175 per month for their medical insurance costs.

According to Plaintiffs, during the course of their employment (and prior to the January 1, 2001 amendment), they and other Blue Cross employees were promised by numerous agents of Blue Cross, acting as fiduciaries of the Plan, that the benefits to which they were entitled under the Plan would be funded entirely by Blue Cross for the remainder of their lives or the lives of their dependents entitled to benefits under the Plan. Consequently, Plaintiffs expected that neither they nor their surviving spouses would contribute to the cost of their health insurance coverage during their retirement.

MOTION FOR SUMMARY JUDGMENT:

A. Breach of Fiduciary Duty

Plaintiffs' Complaint alleges as follows:

46. As a fiduciary under ERISA, Defendant has a duty, pursuant to Section 404(a) of the Act, to administer its Plan solely in the interest of the Plan's participants and beneficiaries.

47. *Defendants' implementation of the revised Plan,* after having represented to Plaintiffs that they would enjoy lifelong health insurance benefits, unfunded entirely by Defendants, *would be a breach of Defendants' fiduciary duty,* under ERISA, to act solely in the interest of Plaintiffs, as participants in the Defendants' Plan.

> 48. *Defendants' implementation of the revised Plan,* in order to enhance its own financial standing, *would be a breach of Defendants' fiduciary duty,* under ERISA, to act solely in the interest of Plaintiffs, as participants in Defendants' Plan.

(*See* Complaint at ¶¶ 46-48) (emphasis added).

The only reasonable interpretation of these allegations is that Plaintiffs' claim for breach of fiduciary duty is based upon the premise that the act of amending the Plan, despite the fact that Blue Cross representatives had previously indicated to Plaintiffs that they and qualified dependents were entitled to fully funded lifetime benefits, amounts to a breach of Blue Cross' fiduciary duty.

We reiterate this point because within their brief in opposition to the Motion to Dismiss, Plaintiffs assert that Blue Cross "has misapprehended the nature of Plaintiffs claims" and that

> [i]t is not Blue Cross's act of amending the Plan that is claimed to be a breach of their fiduciary duties but the acts and omissions of the fiduciaries in counseling the Plaintiffs that, as a retirement benefit, that they had lifetime medical benefits without making reference to the claimed reservation of rights, even though the representatives were aware that many employees mistakenly understood such counsel to mean that such benefits became vested at the time of retirement, and/or in affirmatively representing to the Plaintiffs that their medical benefits were guaranteed once they retired, when the company knew in fact this was not true. (sic)

(Pls.' Br. Opp. Def.'s Mot. Dis. At 7). Plaintiffs' reasoning is unconvincing. The allegations within Plaintiffs' Complaint

are clear and unambiguous: it is the act of implementing the amendment to the Plan, not the act of advising Plaintiffs that they were entitled lifetime fully funded benefits under the Plan, that Plaintiffs have asserted constitutes a breach of Blue Cross' fiduciary duty. We will not permit Plaintiffs to sidestep their obligation to properly plead allegations within their Complaint by adopting arguments within their brief that are inconsistent with the allegations actually plead. *See Pennsylvania ex rel. Zimmerman v. PepsiCo, Inc.,* 836 F.2d 173, 181(3d Cir.1988) (*quoting Car Carriers Inc. v. Ford Motor Co.,* 745 F.2d 1101, 1107 (7th Cir.1984)) ("[I]t is axiomatic that the complaint may not be amended by the briefs in opposition to a motion to dismiss"). In effect therefore, we will consider the viability of Plaintiffs' claim that the January 1, 2001 amendment to the Plan constitutes a breach of fiduciary duty.

To determine whether or not a breach of a fiduciary duty imposed by ERISA has occurred, we must initially determine whether the act complained of constitutes a fiduciary function.[1] *See Horvath v. Keystone Health Plan East, Inc.,* 2002 WL 265023, at *2, 2002 U.S. Dist. Lexis 3042, at *5 (E.D.Pa. Feb. 22, 2002). This determination is relatively uncomplicated in this case because the Third Circuit has specifically held that ERISA fiduciary obligations do not apply to the amendment of an employee benefit plan. *See Walling v. Brady,* 125 F.3d 114, 120 (3d Cir.1997) (*citing Lockheed Corp. v. Spink,* 517 U.S. 882, 889, 116 S.Ct. 1783, 135 L.Ed.2d 153 (1996)); *see also Mushalla v. Teamsters Local No. 863 Pension Fund,* 152 F.Supp.2d 613, 623 (D.N.J.2001) ("Amending, altering or

[1] The various fiduciary duties are set forth in 29 U.S.C. § 1104

terminating a plan . . . does not trigger fiduciary duties regardless of who undertakes those functions."). Therefore, we will grant summary judgment as to Count I of Plaintiff's Complaint.

We do, however, take cognizance of the fact that allegations that fiduciaries intentionally misrepresented the benefits to which plan beneficiaries were entitled may support a breach of fiduciary duty claim. *See Mushalla v. Teamsters Local No. 863 Pension Fund,* 152 F.Supp.2d 613, 627 n. 6 (D.N.J.2001); *see also In re Unisys Corp. Retiree Med. Benefit "ERISA" Litig.,* 242 F.3d 497 (3d Cir.2001) (*Unisys II*). Therefore, we will grant Plaintiffs leave to amend Count I of their Complaint so as to properly plead these allegations.

B. Equitable Estoppel

A plaintiff pursuing an equitable estoppel claim pursuant to ERISA must establish the following elements: "(1) a material representation, (2) reasonable and detrimental reliance on the representation, and (3) extraordinary circumstances." *Curcio v. John Hancock Mut. Life Ins. Co.,* 33 F.3d 226, 235 (3d Cir.1994) (*citing Smith v. Hartford Ins. Group,* 6 F.3d 131, 137 (3d Cir.1993)).

Blue Cross contends that Plaintiffs' equitable estoppel claim is not viable because Plaintiffs cannot establish the *reasonable* reliance element of the cause of action. The cornerstone of Blue Cross' argument is that the 1993 and 1998 summary plan descriptions ("SPDs") each contain reservation of rights clauses ("RORs") which unequivocally provide, respectively, that Blue Cross "may discontinue retiree health coverage for all retirees at any time" and that Blue Cross "reserves the right to modify or amend the

Plan, in whole or in part, or terminate the Plan at any time and for any reason."[2] (Complaint, Ex. A at 6; Complaint, Ex. G at 4). Indeed, the 1993 Plan itself provides that Blue Cross "reserves the right to amend the Plan in any respect and to terminate the Plan for retirees at any time." (Def.'s Mot. Dis. Ex. C at 24).

Plaintiffs' arguments with regard to the viability of their equitable estoppel claim are twofold. First, Plaintiffs cite § 16 of the 1993 SPD, which they assert does not constitute sufficient notice that Blue Cross reserved the right to alter the benefits to which they had been entitled pursuant to the Plan.[3] Section 16 provides as follows:

> **How Retiree health insurance coverage can change:**
>
> Subject to the other conditions of this paragraph, the Employer intends to continue retiree health insurance coverage on a *shared cost basis* after March 31, 1993.
>
> Retirees who retire on or before March 31, 1993, will be covered by the existing retiree health

---

[2] "ERISA's framework ensures that employee benefit plans be governed by written documents and summary plan descriptions, which are the statutorily established means of informing participants and beneficiaries of the terms of their plan and its benefits." *In re Unisys Corp. Retiree Medical Benefit "ERISA" Litig.*, 58 F.3d 896, 902(3d Cir.1995) (citations omitted) (*Unisys I*). "Accordingly, any retiree's right to *lifetime* medical benefits under a plan can only be found if it is established by the terms of the ERISA-governed employee benefit plan." *Id.* (emphasis added).

[3] Portions of § 16 were cited previously in connection with Defendant's argument that the 1993 SPD contained a reservations of rights clause which constituted proper notice to Plaintiffs that the Plan could be amended.

> insurance program until changes are made by the Employer for the succeeding Plan year.
>
> The Employer may *change* the insurance *contracts* providing benefits under this Plan effective the next plan year and a contract change may also reduce benefits, exclude prior covered illnesses, exclude treatments from coverage, and/or change the cost sharing formula.
>
> The Employer and Plan Sponsor may *discontinue* retiree health coverage for all retirees at any time effective with the 1st day of the month after publication in a newspaper of general circulation and any employee newsletter, and notice to retirees.

(Complaint, Ex. A at 6) (emphasis in original). Plaintiffs argue that this language is both vague and ambiguous, and can be "reasonabl[y] read to permit the Plan to change the insurance contract itself but not to permit an amendment to the Plan that would have the effect of changing the cost sharing formula." (Pls.' Br. Opp. Def.'s Mot. Dis. At 16). Next, Plaintiffs maintain that even if the 1993 SPD "is sufficient to have appri[s]ed the Plaintiffs that the [P]lan could be amended to take away their lifetime benefits, the wording of the Defendant's 1999 . . . benefits [book],[4] directly and unequivocally states the exact opposite in terms and language that would clearly and reasonably lead an individual to believe that they had lifetime paid

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[4] Plaintiffs refer to the benefits book as "the 1999 SPD/benefits book" within their Brief in Opposition to Defendant's Motion to Dismiss. However, the Complaint refers to the same exhibit simply as a "benefits book." (Complaint at ¶¶ 26, 39, 40). The latter description is most accurate for there is no indication on the face of the benefits book that it purports to be an SPD.

health insurance." (Pls.' Br. Opp. Def.'s Mot. Dis. at 17). Plaintiffs cite the following language as support of their argument:

> "The no cost health insurance benefit is something that is very important to some of us and is one of the benefits that sets Blue Cross apart from other organizations."
>
> (Complaint, Ex. E at 3).
>
> "During your retirement years you will be faced with several life changes. It is inevitable. However, you do have some control in managing theses [sic] changes. As a retiree of Blue Cross of Northeastern Pennsylvania, you have the peace of mind of knowing that you are covered by an outstanding, comprehensive retirement benefits package. We feel that providing these benefits gives you the comfort and assurance you need in order to enjoy life during your golden years."
>
> (Complaint, Ex. E at 17).
>
> "Retirement means it is time to enjoy the peace of mind that comes from not having to work anymore. Planning travel time, spending time with your family and friends or just plain relaxing may be the focus of your days. The last thing you should have to worry about is your health insurance.
>
> **That is why Blue Cross of Northeastern Pennsylvania is dedicated to providing our retirees with a comprehensive healthcare package."**
>
> (Complaint, Ex. E at 18) (emphasis in original).

Further, Plaintiffs emphasize that the 1999 benefits book does not contain a reservation of rights clause or refer to

Blue Cross' purported right to modify benefit schedules, levels or cost sharing allocations. Plaintiffs contend, in essence, that the language contained in various Plan materials is contradictory and creates an ambiguity as to the exact nature of the benefits to which Plaintiffs were entitled. On this basis, Plaintiffs maintain that the motion for summary judgment must be denied as to their equitable estoppel claim.

Determining whether or not various Plan materials are ambiguous is a question of law for the Court to decide. *Unisys I,* 58 F.3d at 902 (*citing Taylor v. Continental Group,* 933 F.2d 1227, 1232 (3d Cir.1991)).

At the outset, it is important to note that "[e]xtra-ERISA commitments, such as the right to receive free lifetime coverage, must be found in the plan documents and stated in clear and express language." *Id.* at 902 (*citing Wise v. El Paso Natural Gas,* 986 F.2d 929 (5th Cir.1993); *Alday v. Container Corp. of America,* 906 F.2d 660, 665 (11th Cir.1990)). Moreover, "[t]he written terms of the plan documents control and cannot be modified or superseded by the employer's oral undertakings." *Id.* (citations omitted).

In *Unisys I,* a case closely analogous to this one, the plaintiff retirees asserted an equitable estoppel claim against their former employer on the basis of alleged "informal oral and written communications" which described their medical benefits as being "'for life' or for the 'lifetime' of the retiree and spouse." *Unisys I,* 58 F.3d at 900. As in the case at bar, the defendant employer in *Unisys I* responded that regardless of the existence of that terminology, the benefits provided within the plan had not vested because the relevant company benefits plans

contained unambiguous reservation of rights clauses which served to preserve the defendant employer's right to alter the plans. In finding that no inconsistency or ambiguity existed in the plan language, the Third Circuit reasoned that:

> [a]n employer who promises lifetime medical benefits, while at the same time reserving the right to amend the plan under which those benefits were provided, has informed plan participants of the time period during which they will be eligible to receive benefits *provided* the plan continues to exist.

Id. at 904 (emphasis in original).

Consistent with the Third Circuit's holding in *Unisys I,* because Blue Cross stated "clearly and unequivocally" in the SPDs that the company reserved the right to modify or amend the Plan, we hold that Plaintiffs cannot establish the reasonable reliance element of their equitable estoppel claim.[5] *Id.* Summary judgment will therefore be granted as to Count II of Plaintiffs' Complaint.

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[5] Significantly, even the benefits book referred to by Plaintiffs states that the "brochure is intended as an overview only," and that "Blue Cross reserves the right to modify, amend or terminate any benefit programs at any time." (Complaint, Ex. E at 4).

With regard to Plaintiffs' claim that the 1993 SPD can be read to permit changes to the insurance contract but not to the cost sharing formula set forth within the contract in particular, we agree with Blue Cross that "[i]t is simply not reasonable to suggest that this language can be read to mean that the insurance contracts can be changed, but that such a change would not result in a change to the benefits of the participants." (Def.'s Rep. Br. Supp. Mot. Dis. at 10).

C. Bad Faith

ERISA provides that state law claims that "relate to any employee benefit plan" are preempted by the statute. 29 U.S.C. § 1144(a). However, ERISA specifically saves those state laws "which regulat[e] insurance" from preemption. 29 U.S.C. § 1144(b)(2)(a). In this case, there is no dispute that the Pennsylvania Bad Faith Statute ("Section 8371"), 42 Pa. Cons.Stat. Ann. § 8371, "relate[s] to" an employee benefit plan. 29 U.S.C. § 1144(a); *see also Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41, 47, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987) (citing case law for the proposition that the term "relate to" has been given a broad meaning). Therefore, unless Section 8371 "regulates insurance" within the meaning of ERISA such that it falls within the protection of ERISA's savings clause, Plaintiffs' claim of bad faith must be dismissed because it will be superseded by ERISA.

Recently, in *Kentucky Association of Health Plans Inc. v. Miller,* the Supreme Court developed a new two-part test to be utilized in determining whether a state law should be considered one "which regulates insurance" under § 1144(b)(2)(A).[6] *See Kentucky Assoc. of Health Plans Inc. v. Miller,* ___ U.S. ___, 123 S.Ct. 1471, 1479, 155

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[6] Prior to *Miller,* courts utilized case law relating to the McCarran-Ferguson Act to determine whether state laws were preempted by ERISA. *See Miller,* ___ U.S. at ___, 123 S.Ct. at 1478. Three factors were relevant to this analysis: "first, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry." *Id.* (*quoting Union Labor Life Ins. Co. v. Pireno,* 458 U.S. 119, 129, 102 S.Ct. 3002, 73 L.Ed.2d 647 (1982) (emphasis omitted)).

L.Ed.2d 468 (2003). "First, the state law must be specifically directed toward entities engaged in insurance. Second, . . . the state law must substantially affect the risk pooling arrangement between the insurer and the insured." *Miller,* ___ U.S. at ___, 123 S.Ct. at 1479 (*citing Pilot Life,* 481 U.S. at 50, 107 S.Ct. 1549; *UNUM Life Ins. Co. of America v. Ward,* 526 U.S. 358, 368, 119 S.Ct. 1380, 143 L.Ed.2d 462 (1999); *Rush Prudential HMO, Inc. v. Moran,* 536 U.S. 355, 366, 122 S.Ct. 2151, 153 L.Ed.2d 375 (2002)). "[E]ven if Section 8371 satisfies the above criteria to survive preemption, the statute may still be preempted if the statute conflicts with Congress' exclusive remedial scheme of ERISA by providing for an alternative remedy." *McGuigan v. Reliance Standard Life Ins. Co.,* 256 F.Supp.2d 345 (E.D.Pa.2003) (*citing Pilot Life,* 481 U.S. at 52-54, 107 S.Ct. 1549).

Section 8371 provides as follows:

> In an action arising under an insurance policy, if the court finds that the insurer has acted in bad faith toward the insured, the court may take all of the following actions:
>
> (1) Award interest on the amount of the claim from the date the claim was made by the insured in an amount equal to the prime rate of interest plus 3%.
>
> (2) Award punitive damages against the insurer.
>
> (3) Assess court costs and attorney fees against the insurer.

42 Pa.C.S.A. § 8371. By virtue of the fact that the statute applies only to those actions "arising under an insurance policy[,]" we conclude that Section 8371 satisfies the first prong of the *Miller* test. *See McGuigan,* 256 F.Supp.2d 345.

Next, we consider whether Section 8371 "substantially affect[s] the risk pooling arrangement between the insurer and the insured." *Miller,* ___ U.S. at ___, 123 S.Ct. at 1479. In *Pilot Life,* the Supreme Court analyzed the Mississippi common law of bad faith and concluded that it "does not affect a spreading of policyholder risk." *Pilot Life,* 481 U.S. at 50, 107 S.Ct. 1549. The Supreme Court based its conclusion upon the fact that the Mississippi "common law of bad faith does not define the terms of the relationship between the insurer and the insured; it declares only that, whatever terms have been agreed upon in the insurance contract, a breach of that contract may in certain circumstances allow the policyholder to obtain punitive damages." *Id.* at 51, 107 S.Ct. 1549. Like the Mississippi common law of bad faith, Section 8371 serves a remedial function and designates specific awards that a court may grant in the event that a breach of an insurance contract has occurred. On this basis, we conclude that Section 8371, like the Mississippi common law of bad faith, does not substantially affect the risk pooling arrangement between the insurer and insured.[7] *See McGuigan,* 256 F.Supp.2d 345 ("Section 8371 does not substantially affect

[7] Plaintiffs appear to concede that Pennsylvania's Bad Faith Statute does not have the affect [sic] of transferring or spreading a policyholder's risk. Within their Brief in Opposition to Defendant's Motion to Dismiss, Plaintiffs did not argue that Section 8371 met the first of the McCarran-Ferguson factors – that the statute had "the effect of transferring or spreading a policyholder's risk." 59 Stat. 33, as amended, 15 U.S.C. § 1101 *et seq.* Plaintiffs' Brief in Opposition was submitted prior to the *Miller* holding, which enumerated new factors, utilized herein, that courts should examine to determine whether ERISA preemption is warranted. However, the issue of whether Section 8371 affects the risk pooling arrangement between insurers and insureds is common to both the McCarran-Ferguson factors and the *Miller* test.

the risk pooling arrangement between the insurer and the insured . . ."); *see also Morales-Ceballos v. First Unum Life Ins. Co. of Amer.,* 2003 U.S.Dist. Lexis 9801 (E.D.Pa. May 28, 2003) ("Pennsylvania's bad faith statute does not substantially affect the risk pooling arrangement between the insurer and the insured."); *Tutolo v. Independence Blue Cross,* 1999 WL 274975, *3, 1999 U.S.Dist. Lexis 6335, *7 (E.D.Pa. May 5, 1999) (*citing Clancy v. Unum Life Ins. Co. of America,* 1996 WL 543929, *3-4, 1996 U.S.Dist. Lexis 14049, *8-9 (E.D.Pa. Sept. 23, 1996)); *Zimnoch v. ITT Hartford,* 2000 WL 283845, *6, 2000 U.S.Dist. Lexis 2846, *18 (E.D.Pa. Mar. 14, 2000).

Because Section 8371 does not meet the second prong of the *Miller* test, we conclude that it does not fall within the savings clause of ERISA. Section 8371 is therefore preempted by ERISA.[8] Accordingly, summary judgment will be granted as to Count III of Plaintiffs' Complaint.

MOTION PURSUANT TO RULE 56(f):

Federal Rule of Civil Procedure 56(f) provides as follows:

> **When Affidavits are Unavailable.** Should it appear from the affidavits of a party opposing the motion [for summary judgment] that the party cannot for reasons stated present by affidavit facts essential to justify the party's opposition, the court may refuse the application for judgment or may order a continuance to permit

[8] Based on our finding, we will not address whether or not Section 8371 conflicts with ERISA with regard to the remedies available pursuant to each of the statutes.

> affidavits to be obtained or depositions to be taken or discovery to be had or may make such other order as is just.

Fed.R.Civ.P. 56(f) (emphasis in original).

Thus far, the parties in this case have only had the opportunity to conduct discovery relevant to Plaintiffs' Motion for Class Certification. That Motion was denied by this Court on July 9, 2003. Plaintiffs now request additional time to conduct merit based discovery so that they may more adequately present arguments in opposition to the pending Motion for Summary Judgment.

According to the Third Circuit, whether a Rule 56(f) "motion should be granted depends, in part, on what particular information is sought; how, if uncovered it would preclude summary judgment; and why it has not previously been obtained." *Contractors Assoc. of Eastern Pennsylvania, Inc. v. City of Philadelphia,* 945 F.2d 1260, 1266 (3d Cir.1991) (internal quotations and citations omitted).

Here, Plaintiffs have provided an voluminous list and supporting affidavits incorporating information they intend to acquire through discovery which they assert "will demonstrate that the Defendant[ ] ha[s] breached [its] fiduciary duties and will establish that [Defendant is] equitably estopped, by virtue of [its] acts and omissions, from breaching [its] promise to [its] retirees of lifetime, fully company paid, insurance for the retiree and their spouse." (Pls.' Cr. Mot. Purs. Rule 56(f) at 9).

As to the allegation that Blue Cross breached its fiduciary duties to Plaintiffs, for the reasons stated previously in our analysis, Count I does not, as plead, state a

valid breach of fiduciary duty claim. Our conclusion in that regard is based purely upon Plaintiffs' failure to properly plead allegations within their Complaint; an examination of factual disputes was irrelevant to our analysis. Necessarily then, additional discovery would have no value to our determination. The Rule 56(f) motion will therefore be denied with regard to Count I. We note, however, that as a practical matter, discovery as to this claim will in all likelihood recommence since we have granted Plaintiffs leave to file an amended complaint.

Next, we must consider whether additional discovery could impact our holding that summary judgment is appropriate with respect to Plaintiffs' equitable estoppel claim. Plaintiffs have indicated within their Rule 56(f) Motion that the information they intend to discover relevant to this claim includes: "[w]hether the various SPDs in this matter were sufficient to permit Blue Cross to amend the Plan to breach the promise; [w]hether the 1999 brochure amounts to a restatement, without reservation of rights, of the promise to the class members which would, in and of itself, counter the prior claimed reservations of rights[;] . . . [w]hether each Plaintiff in the proposed Class has relied on Defendant's promise of lifelong, company paid, health insurance to determine when they would retire, and in some cases whether they would retire early, or at all[;] . . . [w]hether the Defendant[']s statements (written and oral), acts, actions, representations and/or assertions created an implied contract between the Defendant and the individual members of the class providing for the provision of lifetime health insurance benefits, funded entirely by Defendant[ ], as a bargained for component of the employment contract; [w]hether the Defendant's written statements and assertions created an

express written contract between the Defendant and the individual members of the class providing for the provision of lifetime health insurance benefits, funded entirely by Defendant[ ], as a bargained for component to the employment contract[;][w]hether the Defendant's written statements and assertions created an implied written contract between the Defendant and the individual members of the class providing for the provision of lifetime health insurance benefits, funded entirely by Defendant[ ], as a bargained for component to the employment contract[.]" (Pls.' Cr. Mot. Purs. Rule 56(f) at 4-7).

Our holding that Defendant is entitled to summary judgment with regard to Plaintiff's equitable estoppel claim is premised upon our finding that as a matter of law, Plaintiffs did not establish the reasonable detrimental reliance element of the cause of action. To the extent that Plaintiffs seek additional time within which to discover information supporting their claim of reliance, their request will be denied because any information which would tend to prove reasonable reliance would, by virtue of the nature of a reliance claim, necessarily already be within their possession. Moreover, to the extent that Plaintiffs refer to the existence of a separate express or implied written contract that was breached by Blue Cross, these allegations are not a part of any cause of action asserted within their Complaint and additional discovery as to such claims will not be permitted.

Finally, Plaintiffs have indicated within the list of discoverable information provided that they also seek to discover "[w]hether the acts and omissions of the Defendant were done in bad faith . . . [and][w]hether Defendant's alleged bad faith acts were . . . willful, wanton, malicious and with complete indifference to the rights of

Plaintiffs." (Pls.' Cr. Mot. Purs. Rule 56(f) at 6). However, because the facts specific to the case at bar were irrelevant to our holding that Section 8371 is preempted by ERISA, additional discovery as to this point would be superfluous. Further discovery will accordingly be precluded as to Count III of the Complaint.

CONCLUSION:

Based upon the foregoing, summary judgment will be granted as to Counts II and III of Plaintiffs' Complaint. Summary judgment shall also be granted as to Count I of the Complaint in its present form. However, Plaintiffs shall be afforded a period of time within which to file an amended complaint addressing the concerns cited herein in reference to Count I. In the event that Plaintiffs do not file an amended complaint within the prescribed period, the Clerk shall be directed to close the file on the case.

NOW, THEREFORE, IT IS ORDERED THAT:

1. Defendant's Motion to Dismiss (doc. 9), which has been converted into a motion for summary judgment, is granted. However, Plaintiffs will be granted ten days within which to file an amended complaint relating to their breach of fiduciary duty claim. If an amended complaint is not filed on or by July 25, 2003, the Clerk shall be directed to close the file on this case.

2. Plaintiffs' Cross Motion Pursuant to Rule 56(f) (doc. 47) is denied.

IN THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

ELIZABETH MELLEY, et al.,	:	
Intervenors	:	
v.	:	No. 4:CV-02-1709
BLUE CROSS AND BLUE SHIELD OF NORTHEASTERN PENNSYLVANIA,	:	(Judge Jones)
Defendant.	:	

MEMORANDUM AND ORDER

May 7, 2004

Pending before the Court is the defendant, Blue Cross and Blue Shield of Northeastern Pennsylvania's ("Defendant" or "Blue Cross"), Motion to Dismiss and/or Strike Intervenors' Amended Class Action Complaint ("the Motion"). For the reasons that follow, the Motion will be granted in part and denied in part.

PROCEDURAL HISTORY:

The procedural chronology of this case has been thoroughly set forth in prior orders and is well known to the parties. The following brief recitation of that history is sufficient for purposes of a review of the pending Motion.

The plaintiffs Frank W. Leuthner ("Leuthner") and William Reasner ("Reasner") initiated this action by filing a class action complaint in the United States District Court for the Middle District of Pennsylvania on September 26, 2002. By order dated July 9, 2003, we held that both Leuthner and Reasner were inappropriate class

representatives, and denied their motion for class certification. (*See* Rec. Doc. 50). Thereafter, on November 13, 2002, we issued an order granting the motion to intervene filed by Elizabeth Melley ("Melley") and Jean Mikulis ("Mikulis") (together, "Intervenors"). (*See* Rec. Doc. 82). Intervenors filed a Class Action Complaint on December 2, 2003, (*see* Rec. Doc. 87), and on January 6, 2004, filed an Amended Class Action Complaint so as to comply with orders issued by the Court as of that date. (*See* Rec. Doc. 95). Thereafter, on January 26, 2004, Blue Cross filed the pending Motion.

STANDARD OF REVIEW:

Defendant's Motion has been brought pursuant to Federal Rules of Civil Procedure 12(b)(1) and 12(b)(6). Rule 12(b)(1) is relevant to whether the court has jurisdiction over the subject matter of the dispute, while Rule I2(b)(6) involves the failure to state a claim upon which relief can be granted.

In considering a motion to dismiss, a court must accept the veracity of a plaintiffs allegations. *See Scheuer v. Rhodes*, 416 U.S. 232, 236 (1974); *see also White v. Napoleon*, 897 F.2d 103, 106 (3d Cir. 1990). In *Nami v. Fauver*, 82 F.3d 63, 65 (3d Cir. 1996), our Court of Appeals for the Third Circuit added that in considering a motion to dismiss based on a failure to state a claim argument, a court should "not inquire whether the plaintiffs will ultimately prevail, only whether they are entitled to offer evidence to support their claims." Furthermore, "a complaint should not be dismissed for failure to state a claim unless it appears beyond doubt that the plaintiff can prove no set of facts in support of his claim which would entitle

him to relief." *Conley v. Gibson*, 355 U.S. 41, 45-46 (1957); *see also District Council 47 v. Bradley*, 795 F.2d3 310 (3d Cir. 1986).

FACTS:

The factual details of this case have been set forth in their entirety in prior orders. *See e.g. Leuthner v. Blue Cross & Blue Shield of Northeastern Pa.*, 270 F.Supp.2d 584, 588 (M.D. Pa. 2003). To summarize, Plaintiffs are retired Blue Cross employees who assert that they are participants in the Blue Cross of Northeastern Pennsylvania Retiree Health Insurance Plan ("the Plan"), an employee welfare plan sponsored and administered by Blue Cross which is subject to the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §1001, *et seq.* Mikulis is a retired Blue Cross employee and an alleged participant in the Plan, (*see* Int. Am. Compl. at ¶¶4, 56), and Melley is the wife of a deceased retired Blue Cross employee and also an alleged participant in the Plan. (*See* Int. Am. Compl. at ¶56).

Plaintiffs and Intervenors contend that prior to January 1, 2001, Blue Cross employees had been promised by agents of Blue Cross, acting as fiduciaries of the Plan, "that the benefits to which they were entitled under the Plan would be funded entirely by Blue Cross for the remainder of their lives or the lives of their dependents entitled to benefits under the Plan." *Leuthner*, 270 F.Supp. 2d at 588. As early as September 2000, Plaintiffs and Intervenors were notified that their benefits under the Plan would be modified. (*See* Int. Am. Compl. at ¶48). Effective January 1, 2001, the Plan was amended such that coverage to surviving spouses was eliminated and

eligible retirees received a fixed dollar amount from Blue Cross each month, calculated based upon their years of service to Blue Cross, to be utilized for the purpose of purchasing health insurance coverage. (*See* Int. Am. Compl. at ¶48-51).

DISCUSSION:

Defendant argues that the Motion should be granted for the following reasons: (1) Intervenors' breach of fiduciary duty claim seeks relief that is not authorized by ERISA, (2) the relief sought by Intervenors bears no causal connection to Defendant's alleged misrepresentations, (3) Melley lacks standing to assert a breach of fiduciary duty claim, (4) Intervenors have not alleged the fraud that is the basis of their breach of fiduciary duty claim with sufficient particularity, and (5) Intervenors have not sufficiently alleged the detrimental reliance element of their breach of fiduciary duty claim. Lastly, Blue Cross requests that the Court strike the portion of Intervenors' Amended Complaint that indicates it was filed on September 26, 2002.

A. Relief Available Under ERISA

For the reasons stated within our Order dated February 25, 2004, we hold that Intervenors are not entitled to injunctive relief preventing or reversing the January 1, 2001 amendment to the Plan, but that Intervenors are entitled to monetary relief to the extent that they seek to recover readily identifiable and quantifiable funds which Blue Cross would have spent for Intervenors' health benefits but for the amendment to the Plan. (*See* Order dated February 25, 2004, Rec. Doc. 117 at 20-26).

B. Causal Connection Between Relief Sought and Misrepresentations

"An employee may recover for a breach of fiduciary duty if he or she proves that an employer, acting as a fiduciary, made a material misrepresentation that would confuse a reasonable beneficiary about his or her benefits, and the beneficiary acted thereupon to his or her detriment." *In re Unisys Corp. Retiree Medical Benefit "ERISA" Litigation*, 242 F.3d 497, 505 (3d Cir. 2001) ("Unisys III") (*quoting Adams v. Freedom Forge Corp.*, 204 F.3d 475, 492 (3d Cir. 2000)). We have already held that "[t]he last date that Plaintiffs could have reasonably relied to their detriment upon Defendant's misrepresentations was immediately prior to September 2000, when Plaintiffs assert that they first received notice of the January 1, 2001 Plan amendment." (Rec. Doc. 79 at 18-19). The same holds true for Intervenors, who also acknowledge that they received notice that their benefits under the Plan would be altered as early as September 2000. (*See* Int. Am. Compl. at ¶¶47-48). Therefore, consistent with our prior order, we shall grant this portion of Defendant's Motion to the extent that we hold that Intervenors' actionable claims of reliance are those which occurred prior to, but not after, September 2000.

C. Melley Has Does Not Have Standing

Section 501(a)(3) of ERISA, 29 U.S.C. §1132(a)(3) (2003), authorizes a breach of fiduciary duty claim brought by a "participant, beneficiary, or fiduciary."[1] Under ERISA,

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[1] There is no dispute that Melley does not qualify as a fiduciary of the Plan.

a "participant" is "any employee or former employee . . . who is or may become eligible to receive a benefit . . . from an employee benefit plan." 29 U.S.C. §1002(7) (2003). A "beneficiary" is "a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit hereunder." 29 U.S.C. §1002(8) (2003).

Intervenors have alleged that Melley is, or was at one time, a participant of the Plan. (*See* Int. Am. Compl. at ¶56). Blue Cross challenges the contention that Melley may be designated as a Plan participant and argues moreover that Melley likewise fails to qualify as a beneficiary under the Plan. Based upon the foregoing, Blue Cross contends that Melley lacks standing to assert a breach of fiduciary duty claim against Defendant.[2]

The terms of Intervenors' Amended Class Action Complaint demonstrate that Mulley's connection to Blue Cross exists by virtue of the fact that she is the wife of a retired Blue Cross employee, but is not herself a current or former employee of Blue Cross. These allegations make clear that Melley cannot be considered a "participant" of the Plan as that term is defined under §1002(7).

We turn then to consider whether Melley is a beneficiary of the Plan who has standing to assert a breach of fiduciary duty claim against Blue Cross. Standing is to be determined based on the facts existing when the suit was filed as opposed to the time of the alleged ERISA violation. *See Harris v. Provident Life and Accident Insurance Co.*,

[2] The portion of Blue Cross' Motion addressing Melley's standing to bring a breach of fiduciary duty claim against Blue Cross has been brought pursuant to Federal Rule of Civil Procedure 12(b)(1).

26 F.3d 930, 933 (9th Cir. 1994) ("Whether a person is a plan participant must be decided as of the time of the filing of the lawsuit"); *see also Yankee v. American Petrofina, Inc.*, 768 F.2d 707, 708 (5th Cir. 1485) ("questions of standing must be resolved on the facts existing when the challenge is raised"). Thus, we agree with Blue Cross that in order to have standing to assert a breach of fiduciary duty claim, Melley must have been a Plan "beneficiary" on December 2, 2003, the date that the Intervenors filed their original complaint in this action. With regard to this point, the parties agree that Melley, a spouse of a deceased retired employee of Blue Cross, was entitled to benefits and was therefore a beneficiary of the Plan prior to January 1, 2001. Significantly, the parties likewise agree that as of January 1, 2001, the date that the Plan amendment became effective and benefits to surviving spouses of Blue Cross retirees were eliminated, Melley was no longer receiving benefits under the Plan. Consequently, we hold that Melley does not meet the definition of "beneficiary" based upon a present entitlement to benefits under the Plan.

As to whether or not Melley may be eligible to receive benefits under the Plan at some point in the future so as to satisfy the definition of "beneficiary" under §1002(8), we reiterate that neither Plaintiffs nor Intervenors are entitled to injunctive relief preventing or reversing the January 1, 2001 Plan amendment. (*See* Order dated July 11, 2003, Rec. Doc. 51, at 7-10; *see also* Order dated February 25, 2004, Rec. Doc. 117, at 21-22). In other words, even assuming that Plaintiffs and Intervenors prevail in their cause of action, they will not be entitled to recoup damages in the form of a restoration of the benefits to which they were entitled prior to the Plan amendment.

For these reasons, and because "damages stemming from [Defendant's] alleged breach of fiduciary duty . . . [do] not constitute a "benefit" within the meaning of §1002(8)," *Daniels v. Thomas & Betts Corp.*, 263 F.3d 66, 78 (3d Cir. 2001) (*citing Kuntz v. Reese*, 785 F.2d 1410, 1411 (9th Cir. 1986) ("plaintiffs do not allege that their vested benefits were improperly computed, rather they allege breach of fiduciary duty or of a duty to disclose information about benefits, thus any recoverable damages would not be benefits from the plan.")), we hold that Melley is not presently entitled to Plan benefits and cannot take any action to achieve an entitlement to benefits under the Plan.[3] She does not, therefore, qualify as a beneficiary under the Plan. Accordingly, we hold that Melley does not have standing to sue under ERISA.

D. Allegations of Fraud

Defendant argues that Intervenors' breath of fiduciary duty claim should be dismissed because Intervenors have

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[3] We reject Intervenors' suggestion that "but for" Blue Cross' wrongful conduct, Melley would be a beneficiary entitled to benefits under the Plan. Again, it is Defendant's alleged misrepresentations rather than the act of amending the Plan that are at issue in this case, and Blue Cross' alleged misrepresentations certainly did not in and of themselves divest Melley of her status as a beneficiary. *See Becker v. Mack Trucks, Inc.*, 281 F.3d, 378 (3d Cir. 2002) (*quoting Shawley v. Bethlehem Steel Corp.*, 989 F.2d 652 658-59 (3d Cir. 1993)).

In addition, because we find that under any circumstances Melley will not be entitled to recover benefits pursuant to the Plan and due to our rejection of Intervenors' "but for" argument, we hold that she cannot be considered to be "in the zone of interests ERISA was intended to protect" *Vartanian v. Monsanto Co.*, 14 F.3d 697, 701 (1st Cir. 1994); *and see Eggert v. Merrimac Paper Co., Inc. Leveraged Employee Stock Ownership Plan and Trust*, 2004 WL 719246, *9 (D. Mass. Mar. 31, 2004).

failed to satisfy the heightened pleading requirements for fraud set forth in Federal Rule of Civil Procedure 9(b).

The purpose of Rule 9(b) "is [to] provide defendants with notice of the precise misconduct that is alleged and to protect defendants' reputations by safeguarding them against spurious allegations of immoral and fraudulent behavior." *Bd. of Tars. v. Food town, Inc.*, 296 F.3d 164, 173 n. 10 (3d Cir. 2002) (*quoting In re Burlington Coat Factor Sec. Lifting.*, 114 F.3d 1410, 1418 (3d Cir. 1997)) In order to satisfy that function, Rule 9(b) mandates that "[I]n all averments of fraud or mistake, the circumstances constituting fraud or mistake shall be stated with particularity."

Blue Cross has pointed out that in this case, Intervenors have "failed to identify the Blue Cross employees or representatives who they contend made any misrepresentations to either or both of them, [and have] . . . failed to allege the date(s) of the alleged misrepresentations." (Def.'s Br. Supp. Def.'s Mot. Dis. at 19). Blue Cross contends that Intervenors' bare allegations of fraud, standing alone, are deficient and in contravention of Rule 9(b).

Our Court of Appeals for the Third Circuit has held that "the requirements of [R]use 9(b) may be satisfied if the complaint describes the circumstances of the alleged fraud with precise allegations of date, time or place *or* by using some means of injecting precision and some measure of substantiation into their allegations of fraud." *Food town*, 296 F.3d at 173 n. 10 (internal quotation marks and citations omitted) (emphasis added). Here, Intervenors have alleged *inter alia* that high level Blue Cross employees routinely advised them both orally and in writing that "their medical benefits were guaranteed once they retired

despite knowledge on the part of . . . Defendant that there was no such guarantee of medical benefits." (Int. Am. Compl. at ¶66). Intervenors have set forth the nature of Defendant's oral misrepresentations and have attached copies of the documents they assert contain written misrepresentations as exhibits to the Amended Class Action Complaint. Our review of the foregoing has persuaded us that the allegations of fraud set forth by Intervenors have been plead with sufficient particularity so as to place Defendant on notice of the precise misconduct with which it is charged, thereby fulfilling the purposes of Rule 9(b). *See Seville Industrial Machinery Corp. v. Southmost Machinery Corp.*, 742 F.2d 786, 791 (3d Cir. 1984) ("It is certainly true that allegations of 'date, place or time' fulfill [the] functions [of Rule 9(b)], but nothing in the rule requires them.").

E. Detrimental Reliance

Defendant contends that Intervenors' allegations of detrimental reliance are insufficient to sustain their breach of fiduciary duty claim.

Intervenors have alleged multiple instances of detrimental reliance throughout their Amended Class Action Complaint. (*See* Int. Am. Compl. at ¶¶28, 29, 94-95, 101-102, 105-107). However, each of these allegations is phrased so as to illustrate examples of detrimental reliance taken either by Plaintiffs or by members of the putative class; Intervenors' Amended Class Action Complaint does not at any time identify which of its potential theories of reliance applies to Mikulis, the remaining intervening party.

Because the Amended Class Action Complaint is deficient in that regard, we shall instruct Mikulis to submit a second amended complaint setting forth allegations of detrimental reliance that apply to her individually. We caution Mikulis that in filing a second amended complaint, she should set forth the specific actions she took or refrained from taking in reliance on Blue Cross' alleged misrepresentations and should identify how she was harmed by the asserted action or forbearance. Mikulis should moreover apply our holdings in prior orders, and significantly our Order dated February 25, 2004, in determining the viability of specific allegations.

F. Motion to Strike

Blue Cross objects to the fact that Intervenors' Amended Class Action Complaint "indicates that it was filed on September 26, 2002, the same date Plaintiffs filed their original complaint." (Def.'s Br. Supp. Mot. Dis. Int. Am. Compl. at 22).

Our review of Intervenors' Amended Class Action Complaint indicates that the text of the document specifies the date that the complaint in this action was filed, and immediately below that notation states that intervention in this action was granted on November 13, 2003. We believe that Blue Cross' objection mischaracterizes the information provided on the face of the Amended Class Action Complaint. For the sake of clarity, we note that Intervenors' original complaint was filed on December 2, 2003. It would be both inaccurate and illogical for Intervenors to have alleged that their Amended Class Action Complaint was filed prior to the date that intervention

was granted, and we decline to construe Intervenors' allegations in this mariner.

Because we find that there is no genuine dispute as to the date that submissions in this action were filed with the Court, we find no need to strike any portion of Intervenors' Amended Class Action Complaint.

CONCLUSION:

For the reasons stated above, Defendant's Motion to Dismiss and/or Strike Intervenors' Amended Class Action Complaint will be granted in part and denied in part.

NOW, THEREFORE, IT IS ORDERED THAT:

1. Defendant's Motion to Dismiss And/Or Strike Intervenors' Amended Class Action Complaint (doc. 106) is granted in part and denied in part.

   A. The Motion is granted to the extent that we hold that Intervenors' actionable claims of reliance are those which. occurred prior to, but not after, September 2000; to the extent that we hold that Melley does not have standing to sue under ERISA; and to the extent that Mikulis shall file a second amended complaint in accordance with Part E within ten days of the date of this Order. The Motion is denied in all other respects.

/s/ John E. Jones III
John E. Jones III
United States District Judge

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

ELIZABETH MELLEY, et al., Intervenors	:	
v.	:	No. 4:CV-02-1709
BLUE CROSS AND BLUE SHIELD OF NORTHEASTERN PENNSYLVANIA,	:	(Judge Jones)
Defendant.	:	

MEMORANDUM AND ORDER

September 27, 2004

Pending before the Court is the defendant, Blue Cross and Blue Shield of Northeastern Pennsylvania's ("Defendant"), Motion to Dismiss the Second Amended Class Action Complaint of Jean Mikulis And/Or For Summary Judgment ("the Motion") (doc. 156). For the reasons that follow, the Motion will be granted.

PROCEDURAL HISTORY:

The procedural chronology of this case has been thoroughly set forth in prior orders and is well known to the parties. The following brief recitation of that history is sufficient for purposes of this Court's review of the pending Motion.

The plaintiffs Frank W. Leuthner ("Leuthner") and William Reasner ("Reasner") initiated this action by filing a class action complaint in the United States District Court for the Middle District of Pennsylvania on September 26, 2002. By order dated July 9, 2003, we held that

both Leuthner and Reasner were inappropriate class representatives, and denied their motion for class certification. (*See* Rec. Doc. 50).

Thereafter, on November 13, 2002, we issued an order granting the motion to intervene filed by Elizabeth Melley ("Melley") and Jean Mikulis. ("Mikulis") (together, "Intervenors"). (*See* Rec. Doc. 82). Intervenors filed a Class Action Complaint on December 2, 2003, (*see* Rec. Doc. 87), and on January 6, 2004, filed an Amended Class Action Complaint so as to comply with orders issued by the Court as of that date. (*See* Rec. Doc. 95). We dismissed Melley's amended complaint for lack of standing, but permitted Mikulis to file a second amended complaint. On May 17, 2004, Mikulis filed a second amended complaint. On June 7, 2004, Defendant filed this Motion, which has been briefed by the parties. The Motion is therefore ripe for disposition.

STANDARD OF REVIEW:

Defendant's Motion has been brought pursuant to Federal Rules of Civil Procedure 12(b)(1), 12(b)(6), and/or 56. Rule 12(b)(1) is relevant to whether the court has jurisdiction over the subject matter of the dispute, while Rule 12(b)(6) involves the failure to state a claim upon which relief can be granted. Rule 56 sets forth the standard for summary judgment.

As a general rule, in assessing the sufficiency of a pleading pursuant to Fed.R.Civ.P. 12(b)(6), the court is limited in the sense that it may only consider the pleading being attacked. *See Pryor v. National Collegiate Athletic Ass'n*, 288 F.3d 548, 560 (3d Cir. 2002). We shall construe the Motion under the standard of review appropriate for a

motion to dismiss as the parties' submissions do not include matters outside of the pleadings.

In considering a motion to dismiss, a court must accept the veracity of a plaintiffs allegations. *See Scheuer v. Rhodes*, 416 U.S. 232, 236 (1974); *see also White v. Napoleon*, 897 F.2d 103, 106 (3d Cir. 1990). In *Nami v. Fauver*, 82 F.3d 63, 65 (3d Cir. 1996), our Court of Appeals for the Third Circuit added that in considering a motion to dismiss based on a failure to state a claim argument, a court should "not inquire whether the plaintiffs will ultimately prevail, only whether they are entitled to offer evidence to support their claims." Furthermore, "a complaint should not be dismissed for failure to state a claim unless it appears beyond doubt that the plaintiff can prove no set of facts in support of his claim which would entitle him to relief." *Conley v. Gibson*, 355 U.S. 41, 45-46 (1957); *see also District Council 47 v. Bradley*, 795 F.2d3 310 (3d Cir. 1986).

FACTS:

The factual details of this case have been set forth in their entirety in prior orders. *See e.g. Leuthner v. Blue Cross & Blue Shield of Northeastern Pa.*, 270 F.Supp.2d 584, 588 (M.D. Pa. 2003). To summarize, Plaintiffs are retired Blue Cross employees who assert that they are participants in the Blue Cross of Northeastern Pennsylvania Retiree Health Insurance Plan ("the Plan"), an employee welfare plan sponsored and administered by Blue Cross which is subject to the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §1001, *et seq.* Mikulis is a retired Blue Cross employee and an

alleged participant in the Plan. (*See* Second Am. Compl. at (¶¶4, 6; *see also* Pls.' Br. Opp. Def. Mot. Dismiss at 6).

Plaintiffs and Intervenors contend that prior to January 1, 2001, Blue Cross employees had been promised by agents of Blue Cross, acting as fiduciaries of the Plan, "that the benefits to which they were entitled under the Plan would be funded entirely by Blue Cross for the remainder of their lives or the lives of their dependents entitled to benefits under the Plan." *Leuthner*, 270 F.Supp. 2d at 588. As early as September 2000, Plaintiffs and Intervenors were notified that their benefits under the Plan would be modified. (*See* Second Am. Compl. at ¶¶62, 63). Effective January 1, 2001, the Plan was amended such that coverage to surviving spouses was eliminated and eligible retirees received a fixed dollar amount from Blue Cross each month, calculated based upon their years of service to Blue Cross, to be utilized for the purpose of purchasing health insurance coverage. *Id.*

DISCUSSION:

Defendant argues that the Motion should be granted for the following reasons: (1) Mikulis lacks standing to assert her breach of fiduciary duty claim and (2) Mikulis may not assert a breach of fiduciary duty claim based upon an alleged act of reliance taken more than six years before any complaint was filed in this action. (*See* Def. Br. Mot. Dismiss at 3).

A. Standing Claim

Section 501(a)(3) of ERISA, 29 U.S.C. §1132(a)(3) (2003), authorizes a breach of fiduciary duty claim to be

brought by a "participant, beneficiary, or fiduciary." Under ERISA, a "participant" is "any employee or former employee . . . who is or may become eligible to receive a benefit . . . from an employee benefit plan " 29 U.S.C. §1002(7)(2003) ("§1002(7)). Pursuant to §1002(7), the determination of whether a plaintiff satisfies the definition of "participant" is a two pronged inquiry. First, the plaintiff must be an "employee or former employee" of the defendant. *Id.* Second, the plaintiff must also be a person "who is or may become eligible to receive a benefit . . . from an employee benefit plan." *Id.* It is undisputed by the parties that Mikulis is a "former employee" and therefore satisfies the first prong of the inquiry. Defendant argues that Mikulis is not eligible to receive Plan benefits and cannot take any action to become eligible for Plan benefits. (*See* Def. Br. Motion to Dismiss at 4). Defendant therefore asserts that Mikulis cannot satisfy the second prong of the "participant" inquiry and her breach of fiduciary duty claim must be dismissed for lack of standing.

In determining whether Mikulis is a "participant" of the Plan who has standing to assert a breach of fiduciary duty claim against Defendant, it is important to note that standing is to be determined based on the facts existing when the suit was filed, as opposed to the time of the alleged ERISA violation. *See Harris v. Provident Life and Accident Insurance Co.*, 26 F.3d 930, 933 (9th Cir. 1994) ("Whether a person is a plan participant must be decided as of the time of the filing of the lawsuit."); *see also Yancy v. American Petrofina, Inc.*, 768 F.2d 707, 708 (5th Cir. 1985) (Questions of standing must be resolved on the facts existing when the challenge is raised). Therefore, in order to have standing to assert a breach of fiduciary duty claim, Mikulis must have been a Plan "participant" on December

2, 2003, the date that the Intervenors filed their original complaint in this action.

As of January 1, 2001, the Plan no longer provided employer funded benefits to retirees who had less than fifteen years of service with Defendant at the time they retired. (*See* Second Am. Compl. at ¶39-40; *see also* Second Am. Compl. at Ex. H). It is undisputed by the parties that Mikulis retired with less than fifteen years of service. (*See* Second Am. Compl. at ¶40; *see also* Ex. 1 at 31, 37, 39-40; Ex. 2; Def. Br. Mot. Dismiss at 5). Mikulis was therefore not a Plan "participant" on December 2, 2003, when the complaint was filed. Accordingly, we hold that Mikulis lacks standing to assert a breach of fiduciary duty claim under §501(a)(3) of ERISA.

As to whether or not Mikulis may be eligible to receive benefits under the Plan at some point in the future so as to satisfy the definition of "participant" under §1002(7), we reiterate that neither Plaintiffs nor Intervenors are entitled to injunctive relief preventing or reversing the January 1, 2001 Plan amendment. (*See* Order dated May 7, 2004, Rec. Doc. 144; *see also* July 11, 2003, Rec. Doc. 51, at 7-10; Order dated February 25, 2004, Rec. Doc. 117, at 21-22). In other words, and restating this Court's May 7, 2004 Order, even assuming that Plaintiffs and Intervenors prevail in their cause of action, they will not be entitled to recoup damages in the form of a restoration of the benefits to which they were entitled prior to the Plan amendment. We hold that Mikulis is not presently entitled to Plan benefits and cannot take any action to

achieve an entitlement to benefits under the Plan.[1] We therefore hold that Mikulis does not have standing to assert a breach of fiduciary duty claim under §501(a)(3) of ERISA.

B. Timeliness of Mikulis' Claim

Defendant asserts that because Mikulis' retirement in February 1993 occurred more than six years prior to the filing of the Intervenors' Complaint in December 2003, it is barred. (*See* Def. Br. Mot. Dismiss at 11).

Inasmuch as this Court has held that Mikulis does not have standing to assert a breach of fiduciary duty claim under §501(a)(3) of ERISA, Defendant's assertions that Mikulis' claim is untimely are denied as moot.

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[1] We reject Mikulis' suggestion that "but for" Defendant's wrongful conduct, Mikulis would be a "participant" entitled to benefits under the Plan. As we explained in our May 4, 2004 Order, it is Defendant's alleged misrepresentations, rather than the act of amending the Plan, that are at issue in this case, and Defendant's alleged misrepresentations certainly did not in and of themselves divest Mikulis of her status as participant. *See Becker v. Mack Trucks, Inc.*, 281 F.3d 372, 378 (3d Cir. 2002) (*quoting Shawley v. Bethlehem Steel Corp.*, 989 F.2d 652, 658-59 (3d Cir. 1993)).

Additionally, because we find that under any circumstances Mikulis will not be entitled to recover benefits pursuant to the Plan and due to our rejection of Mikulis' "but for" argument, we hold that she cannot be considered to be "in the zone of interests ERISA was intended to protect." *Vartanian v. Monsanto Co.*, 14 F.3d 697, 701 (1st Cir. 1994); *see also Eggert v. Merrimac Paper Co., Inc. Leveraged Employee Stock Ownership Plan and Trust*, 2004 WL 719246, *9 (D. Mass. Mar. 31, 2004).

NOW, THEREFORE, IT IS ORDERED THAT:

1. The Motion to Dismiss the Complaint the Second Amended Class Action Complaint of Jean Mikulis And/Or For Summary Judgment (doc. 156) is granted.

2. Intervenor Mikulis does not have standing to assert a breach of fiduciary duty claim under §501(a)(3) of ERISA, 29 U.S.C. §1132(a)(3).

/s/ John E. Jones III
John E. Jones III
United States District Judge

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

FRANK W. LEUTHNER, WILLIAM REASNER, Plaintiffs, ELIZABETH MELLEY, JEAN MIKULIS, Intervening Plaintiffs, and ALL OTHERS SIMILARLY SITUATED v. BLUE CROSS AND BLUE SHIELD OF NORTHEASTERN PENNSYLVANIA, Defendant.	:	No. 4:CV-02-1709 (Judge Jones)

MEMORANDUM AND ORDER

November 12, 2004

Pending before the Court is Intervening Plaintiff Jean Mikulis' and Previous Intervening Plaintiff Elizabeth Melley's Joint Motion for Judgment Pursuant to Federal Rule of Civil Procedure 54(b) ("the Motion") (doc. 178). For the reasons that follow, the Motion will be granted.

PROCEDURAL HISTORY:

The procedural chronology of this case has been thoroughly set forth in prior orders and is well known to the parties. The following brief recitation of that history is sufficient for purposes of the Court's review of the pending Motion.

The plaintiffs Frank W. Leuthner ("Leuthner") and William Reasner ("Reasner") initiated this action by filing a class action complaint in the United States District Court for the Middle District of Pennsylvania on September 26, 2002. By order dated July 9, 2003, we held that both Leuthner and Reasner were inappropriate class representatives, and denied their motion for class certification. (*See* Rec. Doc. 50).

Thereafter, on November 13, 2002, we issued an order granting the motion to intervene filed by Elizabeth Melley ("Melley") and Jean Mikulis ("Mikulis") (together, "Intervenors" or "Intervening Plaintiffs"). (*See* Rec. Doc. 82). Intervenors filed a Class Action Complaint on December 2, 2003, (*see* Rec. Doc. 87), and on January 6, 2004, filed an Amended Class Action Complaint so as to comply with orders issued by the Court as of that date. (*See* Rec. Doc. 95). We dismissed Melley's amended complaint for lack of standing, but permitted Mikulis to file a second amended complaint. On May 17, 2004, Mikulis filed a second amended complaint. On September 27, 2004, we issued an order granting Defendant's Motion to Dismiss the Second Amended Class Action Complaint of Mikulis And/Or For Summary Judgment and determined that Intervenor Mikulis did not have standing to assert a breach of fiduciary duty claim under § 501(a)(3) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1132(a)(3). (*See* Rec. Doc. 177).

On October 26, 2004, Intervening Plaintiff Mikulis and previous Intervening Plaintiff Melley filed the instant Motion. On November 8, 2004, Plaintiffs submitted a Revised Certificate of Concurrence With Respect to Intervening Plaintiffs' Motion for Interlocutory Appeal (doc. 180) and therein stated that Defendant's chief counsel

concurred in Plaintiffs' Motion on November 4, 2004. The Motion is therefore ripe for disposition.

STANDARD OF REVIEW:

Federal Rule of Civil Procedure 54(b) provides:

> When more than one claim for relief is presented in an action . . . or when multiple parties are involved, the court may direct the entry of a final judgment as to one or more but fewer than all of the claims or parties only upon an express determination that there is no just reason for delay and upon an express direction for the entry of judgment.

"A district court's determination to grant a Rule 54(b) certification motion is 'predicated on its affirmative answer to two questions, i.e., were the judgments final and were they ready for appeal.'" *Waldorf v. Shuta,* 142 F.3d 601, 608 (3d Cir. 1998) (*quoting Gerardi v. Pelullo,* 16 F.3d 1363, 1368 (3d Cir. 1994)). "A final judgment is 'an ultimate disposition of an individual claim entered in the course of a multiple claims action.'" *Id.* at 611 (*quoting Sears, Roebuck & Co. v. Mackey,* 351 U.S. 427, 436 (1956)).

As previously stated in our August 10, 2004 order, our Court of Appeals for the Third Circuit has instructed that the following factors should be considered in this analysis:

> (1) [T]he presence or absence of a claim or counterclaim which could result in a set-off against the judgment sought to be made final; (2) the relationship between the adjudicated and unadjudicated claims; (3) the possibility that the need for review might or might not be mooted by future developments in the district court; (4) the

> possibility that the reviewing court might be obligated to consider the same issue a second time; and (5) miscellaneous factors such as delay, economic and solvency considerations, shortening the time of trial, frivolity of competing claims, expense, and the like.

Waldorf, 142 F.3d at 609 (citations and internal quotation marks omitted).

FACTUAL BACKGROUND:

The factual details of this case have been set forth in their entirety in prior orders. *See e.g. Leuthner v. Blue Cross & Blue Shield of Northeastern Pa.,* 270 F.Supp.2d 584, 588 (M.D. Pa. 2003). To summarize, Plaintiffs are retired Blue Cross employees who assert that they are participants in the Blue Cross of Northeastern Pennsylvania Retiree Health Insurance Plan ("the Plan"), an employee welfare plan sponsored and administered by Blue Cross which is subject to the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §1001, *et seq.* Mikulis is a retired Blue Cross employee and an alleged participant in the Plan and Melley is the wife of a deceased, retired Blue Cross employee and also an alleged participant in the Plan. (*See* Second Am. Compl. at ¶¶ 4, 6; *see also* Pls.' Br. Opp. Def. Mot. Dismiss at 6).

Plaintiffs and Intervenors contend that prior to January 1, 2001, Blue Cross employees had been promised by agents of Blue Cross, acting as fiduciaries of the Plan, "that the benefits to which they were entitled under the Plan would be funded entirely by Blue Cross for the remainder of their lives or the lives of their dependents entitled to benefits under the Plan." *Leuthner,* 270 F.Supp.

2d at 588. As early as September 2000, Plaintiffs and Intervenors were notified that their benefits under the Plan would be modified. (*See* Second Am. Compl. at ¶¶ 62, 63). Effective January 1, 2001, the Plan was amended such that coverage to surviving spouses was eliminated and eligible retirees received a fixed dollar amount from Blue Cross each month, calculated based upon their years of service to Blue Cross, to be utilized for the purpose of purchasing health insurance coverage. *Id.*

DISCUSSION:

In the Court's order of August 10, 2004, we declined to grant Melley's Motion for Judgment Pursuant to Federal Rule of Civil Procedure 54(b) as it was inappropriate at that time, because the identical issue was involved in Mikulis' claim against Defendant. We stated, "an appeal by Mikulis could necessitate that the Court of Appeals consider the same issue a second time [and] we hold that entry of a final judgment at this time is inappropriate." (*See* Rec. Doc. 175, at 5). To rule otherwise, we explained, would constitute a waste of judicial resources. *See id.* In the aforementioned order of August 10, 2004 the Court also stated, "It would appear, however, that once the Motion to Dismiss the Second Amended Class Action Complaint of Jean Mikulis and/or for Summary Judgment has been disposed of, the entry of a final judgment would no longer constitute a waste of judicial resources." *Id.* at 5, fn.2. Subsequently, on September 27, 2004, we granted Defendant's Motion to Dismiss the Second Amended Class Action Complaint of Jean Mikulis. (*See* Rec. Doc. 177).

Intervening Plaintiffs accurately assert that both Melley and Mikulis were parties to this multiple claim,

multiple party case. (*See* Intervening Pls.' Br. Supp. Joint Mot. for Judgment at 7). In addition, their dismissal from the case resulted in a final judgment as to their claims as either a beneficiary or a participant under Defendant's ERISA governed plan, as well as any other family members and dependents who were not employed by Defendant but claim entitlement to benefits as beneficiaries or participants. *Id.*

The Third Circuit has explained that as to whether there is any just reason for delay in entering the final judgment, the court must "take into account judicial administrative interests as well as the equities involved." *Waldorf,* 142 F.3d at 608 (*quoting Gerardi,* 16 F.3d at 1368-69). As the Court has dismissed Melley and Mikulis' claims in this case, after considering the judicial administrative interests and equities involved, and in light of Defendant's concurrence in the instant Motion, we hold that an appeal no longer constitutes a waste of judicial resources. (*See* Rec. Doc. 180). We shall therefore certify the Court's May 7, 2004 and September 27, 2004 orders as final judgments under FED. R. CIV. P. 54(b).

NOW, THEREFORE, IT IS ORDERED THAT:

1. Intervening Plaintiff Jean Mikulis' and Previous Intervening Plaintiff Elizabeth Melley's Joint Motion for Judgment Pursuant to Federal Rule of Civil Procedure 54(b) (doc. 178) is granted.

/s/ John E. Jones III
John E. Jones III
United States District Judge

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 04-4389

FRANK W. LEUTHNER;
WILLIAM REASNER,
AND ALL OTHERS SIMILARLY SITUATED

ELIZABETH MELLEY; JEAN MIKULIS,

Intervenor-Plaintiffs in District Court

v.

BLUE CROSS AND BLUE SHIELD OF
NORTHEASTERN PENNSYLVANIA

Elizabeth Melley and Jean Mikulis,

Appellants

Before: SCIRICA, *Chief Judge,* SLOVITER,
MCKEE, RENDELL, BARRY, AMBRO, FUENTES,
SMITH, FISHER, VAN ANTWERPEN,
CHAGARES and ROTH[1],
Circuit Judges

ORDER

The petition for rehearing *en banc* filed by the appellants in the above-entitled case having been submitted to the judges who participated in the decision of this Court and to all the other available circuit judges of the circuit in

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[1] Effective May 31, 2006, Judge Roth assumed senior status.

regular active service, and no judge who concurred in the decision having asked for rehearing, and a majority of the circuit judges of the circuit in regular active service not having voted for rehearing by the court *en banc,* the petition for rehearing is **denied.** Judge Fisher voted to grant rehearing.

By the Court,

/s/ JANE R. ROTH
Circuit Judge

Dated: August 9, 2006
par/cc: C.A.R., Esq.
K.T.H., Esq.
J.F.S., Esq.

29 U.S.C. § 1132. Civil enforcement

(a) Persons empowered to bring a civil action

A civil action may be brought –

(1) by a participant or beneficiary –

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title;

(5) except as otherwise provided in subsection (b) of this section, by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter;

(6) by the Secretary to collect any civil penalty under paragraph (2), (4), (5), (6), or (7) of subsection (c)

of this section or under subsection (i) or (1) of this section;

(7) by a State to enforce compliance with a qualified medical child support order (as defined in section 1169(a)(2)(A) of this title);

(8) by the Secretary, or by an employer or other person referred to in section 1021(f)(1) of this title, (A) to enjoin any act or practice which violates subsection (f) of section 1021 of this title, or (B) to obtain appropriate equitable relief (i) to redress such violation or (ii) to enforce such subsection; or

(9) in the event that the purchase of an insurance contract or insurance annuity in connection with termination of an individual's status as a participant covered under a pension plan with respect to all or any portion of the participant's pension benefit under such plan constitutes a violation of part 4 of this title or the terms of the plan, by the Secretary, by any individual who was a participant or beneficiary at the time of the alleged violation, or by a fiduciary, to obtain appropriate relief, including the posting of security if necessary, to assure receipt by the participant or beneficiary of the amounts provided or to be provided by such insurance contract or annuity, plus reasonable prejudgment interest on such amounts.

Note: This was the Code section that was in effect on November 13, 2003, the date intervention was granted.

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

FRANK W. LEUTHNER, WILLIAM REASNER,	Case No: 4:02cv1709
Plaintiffs	COMPLAINT FILED: September 26, 2002
and	
ELIZABETH MELLEY JEAN MIKULIS	INTERVENTION GRANTED November 13, 2003
and	
ALL OTHERS SIMILARLY SITUATED	CLASS ACTION
	JUDGE: Jones
Intervening Plaintiffs	ELECTRONICALLY FILLED [sic]
vs.	
BLUE CROSS OF NORTHEASTERN PENNSYLVANIA	
Defendant	

INTERVENORS
AMENDED CLASS ACTION COMPLAINT

JURISDICTION

1. This action arises under the Employee Retirement Income Security Act of 1974 (herein after "ERISA" or "Act"), 29 U.S.C. §1001, et. seq.

2. This Court has jurisdiction over this matter pursuant to the grant of federal court jurisdiction at Section 502(e) of the Act (29 U.S.C. §1132(e)).

PARTIES
INTERVENING PLAINTIFFS

3. Representative Plaintiff, Jean Mikulis, is an adult individual residing at 33 Westminster Drive, Dallas, PA.

4. Plaintiff Mikulis is a retired employee of Defendant Blue Cross of Northeastern Pennsylvania.

5. Representative Plaintiff, Elizabeth Melley, is an adult individual residing at 1307 Palmer Drive, Springfield, PA 19064.

6. Plaintiff Melley is the wife of Thomas C. Melley, a retired employee of Defendant Blue Cross of Northeastern Pennsylvania.

DEFENDANT

7. Defendant is Blue Cross of Northeastern Pennsylvania, a Pennsylvania corporation for profit, with its principal place of business located at 70 North Main Street, Wilkes-Barre, Luzerne County, Pennsylvania.

8. The following paragraphs are incorporated herein by reference as though fully set forth.

CLASS ACTION ALLEGATIONS

9. The preceding paragraphs are incorporated herein by reference as though fully set forth.

10. Plaintiffs, pursuant to Federal Rule of Civil Procedure 23, assert that the policy of Defendant creates a Class so numerous that a joining of all members is impractical; that there are questions of law or fact common to the Class; that the claims or defenses of the representative party is typical of the claims or

defenses of the Class and that Plaintiffs will fairly and adequately protect the interests of the Class.

11. Upon information and belief the Plaintiff class numbers in excess of 130 persons.

12. In addition, prosecution of separate actions by or against individuals of the Class would create a risk of inconsistent or varying adjudications and/or adjudications with respect to individual members of the Class would as a practical matter be Dispositive of the interests of the other members.

13. Defendant has actively refused to act on grounds generally applicable to the Class.

14. Questions of law or fact, affecting the members of the entire Class predominate over any questions of law or fact affecting only individual members of the Class.

15. The Class action is superior to other available means for the fair and efficient adjudication of this controversy.

WHEREFORE, Plaintiffs request Your Honorable Court grant Class Action status in this matter.

16. The following paragraphs are incorporated herein, by reference, as though fully set forth.

FACTUAL ASSERTIONS

17. The preceding paragraphs are incorporated herein, by reference, as though fully set forth.

18. The Plaintiff class are retired employees of Defendant, or the spouses, widows and/or widowers, of retired employees of the Defendant.

19. Upon information and belief the Plaintiff class numbers in excess of 130 persons.

20. Defendant, Blue Cross of Northeastern Pennsylvania began signing up members in 1939 and has been for almost 65 years, a major provider of health insurance products in Northeastern Pennsylvania. See http://www.bcnepa.com/history.htm

21. From 1939 until 2000 Blue Cross made a policy of promising its employees above average retirement benefits, including lifetime, fully company paid, health insurance for retirees and their spouses, as a method of building employee loyalty and to offset the fact that the pay rates with the Defendant were lower than the employees could have obtained with similar employment and to induce their employees to, *inter alia*, remain employed by the company, resist union organizing, accept voluntary terminations or lay-offs from employment, and/or choose early retirements in lieu of continuing to work.

22. During this time period Blue Cross established itself as a major provider of health insurance products in Northeastern Pennsylvania, in large part based upon its dedicated and efficient work force.

23. Up until 1993 Blue Cross's policy was to provide lifetime, fully company paid, health insurance for any retiree age 55 or older who retired with as little as one (1) year of service.

24. This policy changed in 1993.

25. Prior to the 1993 amendments to the Plan the Plan did not contain any language putting an employee and/or Plan member or beneficiary on notice that the Plan was reserving the right to amend or terminate the Plan.

26. In April 1993 Blue Cross issued a Summary Plan Description, effective date April 01, 1993. Attached hereto as Exhibit "A" is a true and correct copy of the April 1, 1993, Summary Plan Description.

27. At the time of issuing the 1993 SPD Blue Cross's eligible employees were advised that if they retired prior to April 01, 1993, they would receive lifetime, 100% employer paid, health insurance benefits for themselves and their spouses under the pre-1993 plan.

28. Based upon that promise a number of Class Plaintiffs were affirmatively induced to retire.

29. The employees who were induced to retire prior to the implementation of the 1993 plan were induced by false promises and reasonably and detrimentally relied on Defendant's false promise of lifelong, company paid, health insurance to determine when they would retire, whether they would take early retirement and/or whether they would retire at all.

30. Plaintiffs had no reason to believe the Defendant would not do that which it has always done in the past, to wit, pay the cost of healthcare for the lives of its retired employees.

31. But for the reliance of those Plaintiffs that retired under the pre-1993 Plan on Defendant's misrepresentation of paid health insurance for life, said class members would have earned significantly more income, and enjoyed significantly enhanced pension benefits, had they continued to work until their "normal" retirement age.

32. The April 1, 1993, Summary Plan Description, (attached as Exhibit "A") provided at paragraph 9,

> The cost of the healthcare insurance program for retirees, their eligible spouses and

eligible dependents is shared by the employer and the Plan member based on the retiree's years of service with the employer. The employer will pay a portion of the cost of the Plan according the following schedule:

EMPLOYER CONTRIBUTION PERCENTAGE	YEARS OF SERVICE AT RETIREMENT
100%	25+
90%	21-24
80%	17-20
70%	13-16
50%	10-12

Any retiree who is eligible but has less than 10 years of service at retirement may purchase coverage by paying the full cost of the coverage then in effect.

33. Under the 1993 Plan an employee retiring with 25 years of service would receive a 100% employer contribution towards the payment of the health insurance benefit.

34. In early 1999 Plaintiffs and class members were notified that the Plan would be changed, effective May 01, 1999. *See* Benefit Program Changes Questions and Answers, attached hereto as Exhibit "B."

35. On or about, March 4, 1999, Christina Buchina, Blue Cross's Director of Employee Benefits, sent a letter to all retirees, which informed the existing Blue Cross retirees that the 1999 plan changes would not affect them. *See* copy of letter from Christina Buchina that was sent to all retirees on, or about,

March 4, 1999, attached as Exhibit "C." See also Burgess Deposition at pages 131-132 excerpt attached as Exhibit "D."

36. Blue Cross did not retroactively apply the 1999 changes to those retirees that had retired prior to the 1993 changes nor those who retired prior to the 1999 changes.

37. The Defendant's course of conduct in regard to any changes in the retiree health insurance benefit was to make the changes only effective to those employees that retired after the change and not to retroactively apply it to the existing retirees.

38. At the time of making the changes to the retiree health insurance plan in 1999 the Blue Cross retiree pension plan was changed as well and at that time Plaintiffs and class members were notified that those retirees who retired at at least 55 years of age with at least 1 years of service would be grandfathered under the 1994 Benefit Plan, the determination not to retroactively apply the changes further demonstrates the long standing course of conduct of Blue Cross not to retroactively apply changes that would detrimentally effected the current retirees. *See* Memorandum to Bill Reasner, attached as Exhibit "E."

39. In 1999, Defendant issued a Summary Plan Description (SPD) which, regarding post retirement medical insurance, states:

> Retirement means it is time to enjoy the peace of mind that comes from not having to work anymore. Planning travel time, spending time with your family and friends or just plain relaxing may be the focus of your days. The last thing you should have to worry about is your health insurance.

> **That is why Blue Cross of Northeastern Pennsylvania is dedicated to providing our retirees with a comprehensive healthcare package.**

1999 SPD at page 18 (emphasis in original), Book attached as Exhibit "F."

40. Under the 1999 Plan the Defendant would pay a portion of the cost of the retirement health plan according the following schedule:

EMPLOYER **CONTRIBUTION** PERCENTAGE	**YEARS OF SERVICE** AT RETIREMENT
100%	25+
83 1/3%	21-24
66 2/3%	17-20
50%	15-16

41. The 1999 Summary Plan Description issued by the Defendant recognizes that, "The no cost health insurance benefit is something that is very important to some of us and is one of the benefits that sets Blue Cross apart from other organizations." Benefits Book at page 3, attached hereto as Exhibit "F."

42. The 1999 SPD (exhibit "F") goes on to state that:

> During your retirement years you will be faced with several life changes. It is inevitable. However you do have some control in managing these changes. As a retiree of Blue Cross of Northeastern Pennsylvania, you have the peace of mind of knowing that you are covered by an outstanding, comprehensive retirement benefits package. We feel that providing these benefits gives

> you the comfort and assurance you need in order to enjoy life during your golden years.

1999 SPD at page 17.

43. The 1999 SPD contains a reservation of rights which by its title and placement in the 1999 SPD addresses only "active employee benefits" and clearly states that "[a]ll benefits [to which that particular section of the SPD relates] are for full time employees." *See* exhibit "F" at page 4.

44. The relevant section of the 1999 SPD detailing retiree benefits does not contain any reference that in any way would cause a reasonable retiree to believe that they could not rely upon the promises being made to them and were part of Blue Cross's continuing course of conduct of providing incorrect information and misinformation to the retirees in relation to the security and duration of the retirement health insurance benefits and which had the purpose and intent of lulling the retirees into a false sense of security.

45. Accordingly, as recently as March of 1999 the Class Plaintiffs had been affirmatively and intentionally misled into believing that they maintained their full health insurance benefit and that said benefit would not be reduced and/or eliminated by the Defendant.

46. As the retirement plan eligibility evolved, the assurances and promises made to the existing retirees remained the same; as retirees from Blue Cross they, and their spouses, would be entitled under the Plan to lifetime insurance coverage, funded entirely by Defendant, for the remainder of the retiring employees' life and/or the lives of any dependents entitled to benefits under the Plan.

47. However, and despite their repeated promises and prior course of conduct, in September of 2000, the Defendant determined that they would substantially alter the method and amount they provide towards a retired employees' health insurance.

48. In September, October and November 2000 Plaintiffs and class members were notified by Defendant that as of January 01, 2001, Defendant would be requiring Plaintiffs to pay for most, or in some cases all, of the healthcare benefits that had previously been paid for as a lifetime retirement benefit by the Defendant. Representative copies of notices are attached hereto as Exhibit "G."

49. Effective January 1, 2001, under the revision to the Blue Cross Plan, eligible retirees are to receive only a fixed dollar amount per month for the purpose of purchasing health insurance coverage.

50. Effective January 1, 2001, the amount Blue Cross contributes towards a retirees health insurance is as follows:

Years Of Service At Retirement	Monthly Company Contribution
Less than 15	$0
15 to 16	Up to $100
17 to 20	Up to $125
21 to 24	Up to $150
25 or more	Up to $175

See letter attached hereto as Exhibit "G."

51. Additionally, insurance coverage for surviving spouses of retirees was eliminated effective January 1, 2001. *See* Exhibit "G".

52. The offered "monthly company contribution" is grossly inadequate to cover the true and actual costs of procuring health insurance for elderly individuals such as the Class Plaintiffs.

53. As a direct result of this change a great number of the Class Plaintiffs now have little or no insurance.

54. As a result the Class Plaintiffs have been forced to significantly and detrimentally alter their lifestyles due to having to pay for insurance and/or medical bills that they would not have had to pay for had the Defendant not broken its promises to them and breached its fiduciary duties.

55. Prior to the changes, enacted on January 1, 2001, it was the understanding of the subject Class that as a retirement benefit in consideration for their years of dedicated service to the Defendant and/or as an early retirement incentive they would be provided with health insurance coverage for the remainder of their lifetimes, and the lifetime of their surviving spouse.

56. Plaintiffs and Class members are, or were, participants under an ERISA governed Welfare Plan implemented and administered by Defendant.

57. The provisions of said Welfare Benefits Plan were explained to, and reasonably interpreted by, the Plaintiffs as creating a right in Plaintiffs to lifelong, company paid, health insurance retirement benefits.

58. The Welfare Benefits Plan describes and provides for a variety of insurance benefits provided to Plaintiffs and their dependents.

59. The healthcare benefits to which Plaintiffs are entitled under the Plan are funded entirely by the Defendant.

60. Each retired employee, and/or their spouse, comprising the Plaintiff Class, was promised, during the course of their employment and/or at or near the time of his/her retirement that the benefits to which they would be entitled under the Plan would be funded entirely by Defendant for the remainder of the retiring employees' life and/or the lives of any dependents entitled to benefits under the Plan.

61. The promised lifetime insurance coverage was provided as consideration for the early retirement of some of the Class member employees.

62. Prior to their retirement the Class Plaintiffs were not advised by any agent of the Defendant that they would ever have to pay for health insurance coverage during their retirement.

63. Prior to their retirement the Class Plaintiffs were advised by agents of the Defendant that they would not have to pay for health insurance coverage during their retirement.

64. Plaintiffs and class members were consistently told by the authorized agents of the Defendant that in consideration for their years of dedicated service to the Defendant and/or as an early retirement incentive upon their retirement they would receive full health insurance retirement benefits, substantially the same as they had at the time of retirement, for the remainder of their lives and the lives of their surviving spouses, funded by the Defendants as set forth under the retirement health insurance plan in effect at the time of their retirement.

65. Representatives of the Defendant counseled members of the Plaintiffs' Class that they had lifetime medical benefits but in so doing, did not make reference to the Reservation of Rights Clause within the Benefit Plan even though the representatives were

aware that many of the employees mistakenly understood the counsel to mean that the lifetime medical care benefit became vested at the time of retirement.

66. Representatives of the Defendant affirmatively represented to the members of the Plaintiff Class that their medical benefits were guaranteed once they retired despite knowledge on the part of the Defendant that there was no such guarantee of medical benefits.

67. During the employment of those plaintiffs who were employed by Blue Cross, and the employment of the spouses of those plaintiffs who were not themselves employed by the company, and continuing to and beyond the dates of their cessation of employment, Blue Cross engaged in a systematic, pervasive, and continuing course of conduct of actively misinforming and misrepresenting, both orally and in writing, to the employees and their spouses that the company would provide them secure, lifetime post-retirement medical benefits at low or no cost and that they could depend upon the continuing availability of these valuable benefits throughout their retirements.

68. The company's written and oral misrepresentations were emphasized by the company as strong reasons for employees to, inter alia, remain employed by the company, tolerate lower rates of pay than could be obtained with other employers, resist union organizing, accept voluntary terminations or lay-offs from employment, and/or choose early retirements in lieu of continuing to work.

69. The company gained substantial economic advantages from its conduct by, inter alia, curtailing its expenses for salary, fringe benefits, payroll taxes,

severance benefit obligations, and pension and savings plan benefit accruals.

70. The company's misrepresentations to plaintiffs about the duration, security, and value of the retiree medical benefits were not in fact true and the company knew this.

71. Unknown to plaintiffs, the company purported to reserve the right to change, reduce or terminate the medical benefits at any time and for any reason, even after the retirement or disability of an employee.

72. Thus, the benefits were, in the opinion and belief of Blue Cross, terminable at will by the company and were not at all secure or dependable.

73. Notwithstanding the high degree of materiality of these facts to reasonable employees, and the company's simultaneous awareness that employees believed and were acting upon the company's misrepresentations of secure, low-cost or free, lifetime benefits, the company did not disclose the material fact that the benefits were contended to be terminable at will or take any other steps to correct the false information it systematically disseminated about the benefits.

74. The information that was misrepresented to and concealed from plaintiffs and the Class about the true duration, security, and value of the retiree medical benefits was material.

75. There was a substantial likelihood that this misrepresented information would be viewed as important by reasonable employees and their spouses and would mislead them in making adequately informed decisions about whether to stop working for the company, whether to commence receipt of a pension,

whether to seek subsequent employment, and whether to make, or refrain from making, other important personal decisions.

76. There was a substantial likelihood that this concealed information would be viewed as important by reasonable employees and their spouses and would preclude and/or diminish their ability to make adequately informed decisions about whether to stop working for the company, whether to commence receipt of a pension, whether to seek subsequent employment, and whether to make, or refrain from making, other important personal decisions.

77. Blue Cross's high-level managers were aware of employees' confusion about their benefits, but the company failed to clarify or correct the misinformation regarding the health insurance benefits.

78. The company and its staff who participated in disseminating information about the benefits and/or encouraging employees to consider termination of employment and commencement of their retirement benefits, routinely communicated with plaintiffs about the benefits with the intention and expectation that plaintiffs would believe they would receive secure, low-cost or free, health care retirement benefits for their lifetimes. In addition, because the company's conduct created a substantial risk of misleading reasonable employees and their spouses, it was foreseeable that they would be so misled to their detriment.

79. A reasonable fiduciary in Blue Cross's position would have foreseen that this conduct would result in important decision making by employees and their spouses based on the mistaken belief that they possessed guaranteed lifetime health care insurance benefits.

80. The following paragraphs are incorporated herein by reference as though fully set forth.

BREACH OF FIDUCIARY DUTY UNDER ERISA

81. The preceding paragraphs are incorporated herein by reference as though fully set forth.

82. At all pertinent times, defendant Blue Cross acted as the named fiduciary, administrator, and fiduciary of the Plan.

83. One of its administrative activities governed by ERISA's strict fiduciary duties was the dissemination of information about the terms of the retiree medical benefits provided to retired employees and their eligible spouses and dependents.

84. From time to time, Blue Cross called upon and delegated to its employee-agents its fiduciary responsibility to provide information about the post-retirement health insurance benefits.

85. In performing these activities, Blue Cross was governed by the fiduciary duties of Section 404(a) of ERISA, 29 U.S.C. § 1104(a).

86. These fiduciary duties include the duty to act solely in the interest of plan participants and beneficiaries, to act with utmost loyalty to them, to disclose truthful information about plan benefits, and to refrain from misrepresenting the terms of the plan.

87. As administrator of a Welfare Benefit Plan, Blue Cross is a fiduciary, as this term is defined in ERISA.

88. Defendant violated its strict ERISA fiduciary duties to plaintiffs on a continuing basis by misrepresenting the true nature of the retiree medical benefits

and concealing the fact that the company actually purported to reserve the right to amend or terminate the benefits at any time for any reason.

89. This information about the benefits was material.

90. Plaintiffs believe, and therefore aver that the revisions to Defendant's Plan, including co-payment by Plaintiffs of a portion of the cost of the healthcare the Defendant had previously provided at no cost to Plaintiff, were at least in part, motivated by considerations of Defendant's financial gain.

91. As a fiduciary under ERISA, Defendant has a duty, pursuant to Section 404(a) of the Act, to administer its Plan solely in the interest of the Plan's participants and beneficiaries.

92. Defendant's implementation of the revised Plan, after having represented to Plaintiffs that they would enjoy lifelong health insurance benefits, funded entirely by the Defendant, is a breach of Defendant's fiduciary duty, under ERISA, to act solely in the interest of Plaintiffs, as participants in the Defendant's Plan.

93. Defendant's implementation of the revised Plan, in order to enhance its own financial standing, would be a breach of Defendant's fiduciary duty, under ERISA, to act solely in the interest of Plaintiffs, as participants in Defendant's Plan.

94. As a result of the company's misrepresentations and omissions, each plaintiff and Class member and/or his/her spouse (if any) were induced to either act, or fail to act, to their detriment with respect to important life decisions, including, but not limited to, personal and family financial decisions, such as decisions to stop working for the company and retire, to begin receiving a company pension, not to seek

additional employment or more remunerative employment, and/or decisions regarding household budgeting, savings, investing, and other sources of medical coverage.

95. Each plaintiff thereby suffered substantial financial injury as a result of their detrimental reliance upon the defendant's Breach of Fiduciary duties.

96. The company either knew, or as a reasonable fiduciary should have foreseen, that its conduct would have these effects on employees and their spouses such as plaintiffs.

97. Defendant misrepresented to Plaintiffs and class members that it would pay for lifelong retirement health insurance coverage, funded entirely by the Defendant, with a knowledge or belief by Defendant that it could not reasonably pay the full cost of healthcare benefits for the life of all of its retired employees. Nevertheless Blue Cross made a policy of promising its employees above average retirement benefits, including lifetime, fully company paid, health insurance for retirees and their spouses, as a method of building employee loyalty and to offset the fact that the pay rates with the Defendant were lower than the employees could have obtained with similar employment and to induce their employees to, *inter alia*, remain employed by the company, resist union organizing, accept voluntary terminations or lay-offs from employment, and/or choose early retirements in lieu of continuing to work.

98. Plaintiffs had no reason to believe the Defendant would not do that which it has always done in the past, to wit, pay the cost of healthcare for the lives of its retired employees.

99. The company either knew, or as a reasonable fiduciary should have foreseen, that its conduct would have these effects on employees such as plaintiffs.

100. The acts and omissions of the fiduciaries in counseling the Plaintiffs that, as a retirement benefit, they had lifetime medical benefits without making reference to the claimed reservation of rights, even though the representatives were aware that employees mistakenly understood such counsel to mean that such benefits became vested at the time of retirement, and/or in affirmatively representing to the Plaintiffs that their medical benefits were guaranteed once they retired, when the company knew in fact that this was not true constitute breaches of their fiduciary duties.

101. Each Plaintiff in the proposed Class detrimentally relied on Defendant's promise of lifelong, company paid, health insurance retirement benefits to determine when they would retire, and in some cases whether they would retire early, or at all.

102. Each Plaintiff in the proposed Class detrimentally relied on Defendant's promise of lifelong, company paid, health insurance to make life decisions after their retirement with respect to important personal and family financial decisions, such as decisions to stop working for the Defendant and/or other employers and retire, to begin receiving a pension, not to seek additional employment or more remunerative employment, and/or decisions regarding household budgeting, savings, investing, and other sources of medical coverage.

103. Blue Cross's promise of lifetime health insurance was a material representation.

104. Prior to the 1993 amendments to the Plan the Plan did not contain any language putting an employee

and/or Plan member or beneficiary on notice that the Plan was reserving the right to amend or terminate the Plan.

105. Those members of the Class retiring prior to the implementation of the 1993 Plan reasonably relied on the fact that as the plan they retired under did not contain any reservation of rights permitting Blue Cross to modify or amend the Plan to take away their promised benefits that Blue Cross could not do so.

106. Each Plaintiff in the proposed Class that retired under the pre-1993 Plan reasonably and detrimentally relied on Defendant's promise of lifelong, company paid, health insurance to determine when they would retire, whether they would take early retirement and/or whether they would retire at all.

107. But for the reliance of the Plaintiffs and class members on Defendant's misrepresentation of paid health insurance retirement benefits for life the Plaintiffs and class members would have earned significantly more income, and enjoyed significantly enhanced pension benefits, had they continued to work until their "normal" retirement age.

WHEREFORE, Plaintiffs request that this Court:

- enjoin Defendant from implementing the revised Plan and/or;
- order the Defendant to reinstitute the Plan as it was in existence prior to the changes complained of, and/or;
- order the Defendant to provide Plaintiffs with comparable lifetime health insurance for themselves and their wives, and/or;

- order the Defendant to repay to Plaintiffs the full amount of money they have paid to provide comparable health care coverage for themselves and their wives, and/or;
- award Plaintiffs a sum of money sufficient to procure comparable insurance for themselves and their wives, and/or;
- award them the reasonable legal fees and costs of this action, and such other legal and equitable relief as the Court may deem just and necessary.

RIEDERS, TRAVIS, HUMPHREY,
HARRIS, WATERS &
WAFFENSCHMIDT

/s/ Clifford A. Rieders

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CERTIFICATE OF SERVICE

AND NOW comes Rodney Lee Knier, Esquire, Attorney for Plaintiffs and certifies that a copy of the foregoing Amended Intervenors Complaint has been served upon Kristofor Henning, Esquire and John Schultz, Esquire; Drinker Biddle & Reath; One Logan Square; Philadelphia, PA 19103-6996, this January 6, 2004, by Electronic Filing.

RIEDERS, TRAVIS, HUMPHREY,
HARRIS, WATERS &
WAFFENSCHMIDT

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[Exhibits Omitted In Printing]

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

FRANK W. LEUTHNER, WILLIAM REASNER, Plaintiffs, JEAN MIKULIS, Intervenor, and ALL OTHERS SIMILARLY SITUATED Intervening Plaintiffs vs. BLUE CROSS OF NORTHERN PENNSYLVANIA Defendant	: CASE NO.: 4:02cv1709 : ORIGINAL COMPLAINT FILED: September 26, 2002 : INTERVENTION GRANTED: November 13, 2003 : INTERVENORS' COMPLAINT FILED: December 2, 2004 : CLASS ACTION : JUDGE: JONES : ELECTRONICALLY FILED

SECOND AMENDED CLASS ACTION COMPLAINT OF JEAN MIKULIS

1. This action arises under the Employee Retirement Income Security Act of 1974 (hereinafter "ERISA" or "Act"), 29 U.S.C. §1001, *et. seq.*

2. The Court has jurisdiction over this matter pursuant to the grant of federal court jurisdiction at Section 502(e) of the Act (29 U.S.C. §1132(e)).

3. Representative Intervening Plaintiff, Jean Mikulis (hereinafter "Plaintiff Mikulis") is an adult individual, age 73, residing at 33 Westminster Drive; Dallas, PA.

4. Plaintiff Mikulis is a retired employee of Defendant Blue Cross of Northeastern Pennsylvania (hereinafter "Defendant").

5. Defendant is a Pennsylvania corporation for profit, with its principal place of business located at 70 North Main Street, Wilkes-Barre, Luzerne County, Pennsylvania.

6. Plaintiff Mikulis and prospective Members of the Plaintiff Class (hereinafter "Class Members") are retired employees of Defendant.

7. Upon information and belief, the number of Class Members is in excess of 130 persons.

8. Plaintiffs, pursuant to Federal Rule of Civil Procedure 23, assert that the policy of Defendant creates a class so numerous that a joining of all members is impractical; that there are questions of law or fact common to the class; that claims or defenses of the representative party are typical of the claims or defenses of the class and that Plaintiff Mikulis will fairly and adequately protect the interests of the Class Members.

9. In addition, prosecution of separate actions by or against Class Members would create a risk of inconsistent or varying adjudications, and/or adjudications with respect to individual Class Members would, as a practical matter, be dispositive of the interests of the other Class Members.

10. Class action is superior to other available means for the fair and efficient adjudication of this controversy.

11. Questions of law or fact affecting Class Members predominate over any questions of law or fact affecting only individual members of the Class.

12. Defendant began signing up members in 1939 and has been, for almost 65 years, a major provider of health insurance coverage in Northeastern Pennsylvania. *See* http://www.bcnepa.com/history.htm

13. From 1939 until 2000, with the latter date being subsequent to the retirement date of Intervenor Mikulis and other Class Members, it was Defendant's policy and practice to promise and provide to all employees, above average retirement benefits, including lifetime health insurance coverage for participants and beneficiaries.

14. Defendant represented to Plaintiff Mikulis and Class Members that, as a retirement benefit, participants and beneficiaries were entitled to lifetime, company paid health insurance benefits for participants and beneficiaries, without making any reference to Defendant's claimed reservation of the right to reduce or eliminate these benefits.

15. Defendant was aware that as a result of what was represented to Plaintiff Mikulis and Class Members, they were led to believe said health insurance benefits became "vested" at the time of retirement.

16. Defendant never gave either Plaintiff Mikulis or Class Members any indication that the benefits were in fact not guaranteed and that Defendant intended to reduce or eliminate said medical benefits whenever it saw fit.

17. Defendant made the misrepresentations at issue to Plaintiff Mikulis and Class Members with the knowledge or belief that it could not reasonably continue to pay the full cost of their health care benefits, or that it would not continue to pay for them.

18. Defendant's promise was a material representation.

19. Defendant used the misrepresentation to recruit employees and maintain current employees at lower salaries than they would have otherwise demanded because of the allegedly superior benefits provided.

20. The offer of lifetime, one hundred percent company paid health insurance coverage for participants and beneficiaries figured prominently in Defendant's efforts to convince prospective employees to work for the company, to convince employees to stay without making increased salary demands or threatening to unionize and/or in some instances, to cause employees to retire early in order to keep the benefit.

21. Plaintiff Mikulis and each Class Member detrimentally relied upon Defendant's promise of lifelong, company paid health insurance benefits for themselves and their designated beneficiaries to make important decisions affecting their lives.

22. These decisions included whether and when to retire and whether to seek employment elsewhere for higher compensation or stay and demand higher pay, whether to unionize to improve their bargaining position pursuant to employment issues, including salary and benefits, whether to investigate alternate sources of health care insurance and/or, at the very least, whether to adjust their budgets by spending less and saving more in anticipation of the increased, future cost of health care and health insurance premiums.

23. Plaintiff Mikulis and Class Members accepted Defendant's word; Defendant had never amended their retirees' benefits and any changes were applied prospectively only.

24. Moreover, Plaintiff Mikulis and Class Members were assured by Defendant that they would also be able to keep their benefits without amendment upon retirement as well.

25. If Plaintiff Mikulis and Class Members would have known that Defendant would reduce and/or eliminate the benefit of lifetime, company paid health insurance coverage, they would have been able to better prepare for their retiremnt as stated *supra.*

26. Plaintiff Mikulis and other Class Members actually retired early, based upon Defendant's misrepresentations to them.

27. Plaintiff Mikulis retired from Defendant in February of 1993.

28. Prior to the 1993 amendments to the Plan, the Plan was devoid of any language putting a participant or beneficiary on notice that Defendant reserved the right to amend, reduce or eliminate benefits.

29. In November of 1992, Defendant told Plaintiff Mikulis and Class Members from this period that they had to retire by April 1, 1993 in order to be eligible for the promised lifetime, one hundred percent company paid health insurance coverage for participants and beneficiaries, without regard to the number of years employed.

30. This information was distributed to Plaintiff Mikulis and other Class Members by a memorandum issued to employees and was also stated by Defendant's Human Resources representative at meetings with employees.

31. Plaintiff Mikulis and other Class Members were informed that if they did not retire prior by April 1, 1993, they would receive retirement health benefits at the time of future retirement based upon a percentage formula related to years of employment.

32. Plaintiff Mikulis, and Class Members similarly situated determined that retirement prior to April 1, 1993, was in their best interests, primarily because

they were assured lifetime one hundred percent employer funded retirement health benefits.

33. Plaintiff Mikulis did not want to retire; she loved her job and wanted to remain in Defendant's employ.

34. The revised Plan, effective April 1,1993, included a Summary Plan Description ("SPD"). Attached hereto as Exhibit "A".[1]

35. Based upon the prospective revisions, Plaintiff Mikulis and similarly situated Class Members felt they had no choice but to retire to protect their health insurance benefits.

36. Due to the early retirement of Plaintiff Mikulis and the other Class Members, they received a smaller pension and reduced Social Security benefits than they otherwise would have been entitled to receive; this detriment has continued from time of retirement to the present and will continue into the future.

37. In addition to less retirement income, had Plaintiff Mikulis and Class Members known Defendant would reduce and/or eliminate their health insurance benefits regardless of their decisions to accept early retirement, they would not only have remained working for Defendant but would also have saved more, in anticipation of having to pay for their own health insurance coverage.

38. Further, subsequent changes to the Plan have been made by Defendant which tie years of employment to employees' eligibility to receive various percentages of

[1] Note the attached Memorandum is dated April 1, 1993, but Item No. 7 in the SPD gives the Effective Date as March 31, 1993; then, Item No. 9, second paragraph, begins "[e]ffective April 1, 1993 . . . ".

reimbursement by Defendant for payment of health insurance costs.[2]

39. These subsequent changes have resulted in Plaintiff Mikulis, and upon information and belief, other Class Members being ineligible for even the minimum payment towards health insurance costs by Defendant, which requires fifteen years of service to Defendant.

40. Plaintiff Mikulis and other Class Members who retired with less than fifteen years of service now receive no contributions whatsoever for payment of their health care insurance costs.

41. Had Plaintiff Mikulis and similarly affected Class Members known the truth, they could have determined whether it would have benefited them financially to continue working, rather than retire early, to qualify for at least some contribution by Defendant to their health care insurance costs.

42. As a result, Plaintiff Mikulis and Class Members have been financially harmed by both their actions and their forebearance [sic], both caused by their reliance on Defendant's misrepresentations.

43. Plaintiff Mikulis has had to return to the work force, but can only find employment at wages which are substantially less than those to which she would have been entitled for her years of service in Defendant's employ.

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[2] Plaintiff Mikulis and Class Members acknowledge the Court's determination that in support of their claims Plaintiffs can only aver actions taken by Plaintiffs up to and including September 2000; however, we respectfully request the Court allow averments reflecting occurrences subsequent to September 2000 which are offered to show not actions taken, but rather the resulting harm/detriment suffered by Plaintiffs.

44. Plaintiff Mikulis has been forced to use her savings by redeeming Certificates of Deposit to supplement her income.

45. Upon information and belief, Class Members have been similarly adversely affected by their reliance upon Defendant's misrepresentations.

46. As indicated, *supra*, Plaintiff Mikulis and Class Members have relied upon Defendant's policy and practice of applying benefits changes only prospectively, never retroactively.

47. For example, the application of the 1993 Plan Amendments affected only future retirees, that is, those who would retire after April 1, 1993.

48. Such prospective applicability of the revised Plan was a continuation of the common practice of Defendant to honor its commitments to retirees and not reduce benefits of those already retired, further justifying the reasonable reliance which Plaintiff Mikulis and other Class Members placed upon Defendant's assurances that Defendant would be responsible for one hundred percent lifetime payment of their health care insurance (and their beneficiaries') after retirement.

49. Even after April 1, 1993, under the revised Plan, employees with twenty-five or more years of service were to continue to receive one hundred percent lifetime employer contribution in payment of the retirees' health insurance coverage. *See* Exhibit A.

50. A new SPD was issued effective August 1, 1998. Exhibit "B" attached hereto.

51. In the accompanying Memorandum, Ms. Buchina wrote that Defendant "is committed to enhancing communication on the benefit programs we offer employees *and* retirees." Exhibit "C" attached hereto (emphasis supplied).

52. On page 16 of the SPD, there appears a section entitled "How Retiree health insurance coverage *can* change" Exhibit B (emphasis supplied).

53. Given the policy and procedure of Defendant, Plaintiff Mikulis and Class Members reasonably believed that any such changes would be applied prospectively and not to current retirees.

54. By Memorandum dated March 3, 1999, to Mr. William Reasner (Plaintiff in the above captioned matter), Ms. Buchina explained that the revisions to the benefit pension plan occurring at that time would not apply to him as he was "grandfathered" under the old pension plan (Exhibit "D" attached hereto); this is yet another example (albeit of the pension plan) of changes not applying to current retirees.

55. By form letter dated March 4, 1999, Ms. Buchina wrote that recent changes had been made to medical benefits offered to *future* retirees (Exhibit[3] "E" attached hereto) (emphasis supplied); Ms. Buchina assured the reader that "the change will have **no impact on you**." (Emphasis in bold in the original.)

56. On March 3, 1999, Thomas J. Ward, Defendant's President and CEO at that time, wrote a letter to "Blue Cross *Employees*" (Exhibit "F" attached hereto), which introduced a brochure regarding employee benefits (Exhibit "G" attached hereto) (emphasis added).

57. Once again, any 1999 changes were not retroactively applied to employees who had retired prior to this date, which obviously included those that retired prior to the 1993 changes.

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[3] Ms. Buchina admitted this in her April 10, 2003 deposition.

58. Nevertheless, in explanation of its retirement benefits, the brochure said:

> Retirement means it is time to enjoy the peace of mind that comes from not having to work anymore. Planning travel time, spending time with your family and friends or just plain relaxing may be the focus of your days. The last thing you should have to worry about is your health insurance.
>
> **That is why Blue Cross of Northeastern Pennsylvania is dedicated to providing our retirees with a comprehensive healthcare package.**

Exhibit G at 18 (emphasis in original).

59. Another excerpt from this Benefits Booklet informed employees and retirees such as Plaintiff Mikulis and Class Members as follows: "[T]he no cost health insurance benefit is something that is very important to some of us and is one of the benefits that sets Blue Cross apart from other organizations." *Id.* at 3.

60. The Booklet continued:

> During your retirement years you will be faced with several life changes. It is inevitable. However you do have some control in managing these changes. As a retiree of Blue Cross of Northeastern Pennsylvania, you have the peace of mind of knowing that you are covered by an outstanding, comprehensive retirement benefits package. We feel that providing these benefits gives you the comfort and assurance you need in order to enjoy life during your golden years.

Id. at 17. In large, bold font, the Booklet stated "We take away the concern you may have about obtaining coverage." *Ibid.*

61. Plaintiff Mikulis and Class Members reasonably relied upon the representations of Defendant, as demonstrated by the aforesaid Exhibits, that Defendants were truthful when they told Plaintiff Mikulis and Class Members they needn't worry about changes to their benefits.

62. It was not until 2000 that Plaintiffs, Plaintiff Mikulis and/or Class Members were notified by Defendant that as of January 1, 2001, Defendant would now require them to pay for most, or in some cases all, of the healthcare insurance benefits previously guaranteed them for life. Representative copies of notices are attached hereto as Exhibit "H."

63. Under the revision, eligible retirees would receive only a fixed dollar amount per month for the purpose of purchasing health insurance coverage; additionally, insurance coverage for surviving spouses of retirees was eliminated effective January 1, 2001.

64. Plaintiff Mikulis and Class Members aver the "monthly company contribution" is grossly inadequate to cover the current true and actual costs of procuring health insurance for elderly individuals, let alone future costs.

65. As a direct result of this change, Plaintiff Mikulis and Class Members now have little or no insurance; at best, any current and anticipated future health insurance coverage is vastly less comprehensive than that upon which Defendant led them to believe they could rely upon in retirement.

66. Plaintiffs Mikulis and Class Members have been forced to significantly and detrimentally alter their

lifestyles due to money which must now be diverted to pay for insurance and/or medical bills they had been assured by Defendant would not be their concern in retirement.

BREACH OF FIDUCIARY DUTY UNDER ERISA

67. The preceding paragraphs are incorporated by reference as if fully set forth.

68. Defendant represented to Plaintiff Mikulis and Class Members that that [sic] they had lifetime medical benefits; in so doing, Defendant did not make reference to the Reservation of Rights Clause within the Benefit Plan, even though Defendant's representatives were aware that many of the employees mistakenly understood Defendant's representatives who counseled employees as to their benefits to mean that the lifetime medical care benefit became vested at the time of retirement.

69. Representatives of the Defendant affirmatively represented to Plaintiff Mikulis and Class Members that their employer funded medical benefits were guaranteed once they retired, despite knowledge on the part of the Defendant that there was no such guarantee of medical benefits.

70. During the employment of Plaintiff Mikulis and Class Members, Defendant engaged in a systematic, pervasive, and continuing course of conduct of actively misinforming and misrepresenting, both orally and in writing, to its employees and their beneficiaries under the Plan that Defendant would provide them secure, lifetime post-retirement health care benefits at low or no cost which they could depend upon throughout their retirement years.

71. Defendant gained substantial economic advantages from its conduct by, *inter alia*, curtailing its expenses

for salary, fringe benefits, payroll taxes, severance benefit obligations, and pension and savings plan benefit accruals.

72. Defendant was also motivated to reduce benefits because of an accounting change mandated by the Federal Accounting Standards Board, wherein the manner in which Defendant accounted for its retirement benefits was now to be done in such a way that it created a negative impact to Defendant's balance sheet.

73. Unknown to Plaintiff Mikulis and Class Members, Defendant purported to reserve the right to change, reduce or terminate the medical benefits at any time and for any reason, even after the retirement or disability of an employee.

74. Notwithstanding the high degree of materiality of these facts to reasonable employees, and Defendant's simultaneous awareness that employees believed and were acting upon the company's misrepresentations of secure, low-cost or free, lifetime benefits, the company did not disclose the material fact that the benefits were contended to be terminable at will or take any other steps to correct the false information it systematically disseminated about the benefits.

75. The information that was misrepresented to and concealed from Plaintiff Mikulis and Class Members about the true duration, security, and value of the retiree medical benefits was material.

76. There was a substantial likelihood that this misrepresented and concealed information would be viewed as important by reasonable employees/participants and their beneficiaries and that failure to disclose the

truth would mislead them, resulting in their inability to make informed financial decisions as set forth, *supra.*

77. Defendant's high-level managers were aware of employees' confusion about their benefits, but Defendant failed to clarify the information or alleviate the confusion.

78. Defendant's staff disseminated the conflicting benefits information, encouraged employees to remain employed with Defendant or conversely accept early retirement while not giving employees such as Plaintiff Mikulis and Class Members accurate and true information concerning their benefits; in fact, Defendant rarely gave out any information at all about the subject.

79. Plaintiff and Class Members who made inquiry about their benefits were routinely told that such things were not within their concern and that they would be fairly taken care of.

80. Defendant dealt with Plaintiff Mikulis and Class Members in a manner that benefited only Defendant.

81. Because Defendant's conduct created a substantial risk of misleading reasonable employees/participants and their beneficiaries, it was foreseeable that they would be so misled to their detriment.

82. A reasonable fiduciary in Blue Cross's position would have foreseen that this conduct would result in important decision making by employees and their spouses based on the mistaken belief that they possessed guaranteed lifetime health care insurance benefits.

83. At all pertinent times, Defendant acted as the named fiduciary, administrator, and fiduciary of the Plan at issue.

84. One of Defendant's administrative duties under the rules of ERISA was the dissemination of information regarding the terms of the retirees' medical benefits to retired employees and their beneficiaries.

85. In performing these activities, defendant was governed by the fiduciary duties of Section 404(a) of ERISA, 29 U.S.C. §1104(a).

86. As a fiduciary under ERISA, Defendant has a duty, pursuant to Section 404(a) of the Act, to administer its Plan solely in the interest of the Plan's participants and beneficiaries. These fiduciary duties include the duty to act solely in the interest of plan participants and beneficiaries, to act with utmost loyalty to them, to disclose truthful information about plan benefits, and to refrain from misrepresenting the terms of the plan.

87. Plaintiff Mikulis and Class Members believe, and therefore aver that the revisions to the Plan were motivated by Defendant's pursuit of financial gain without any consideration of the interests of retirees such as Plaintiff Mikulis and Class Members, in contravention of ERISA.

88. In so doing, Defendant breached its duty by acting in its own interests, rather than the interests of Plaintiff Mikulis and Class Members.

89. The new expenses Plaintiff Mikulis and Class Members must expend for their health insurance coverage has diminished their savings, as their budgeting must now take into account new expenses for health insurance costs, resulting in a negative impact on their finances, which will most likely worsen, given the

escalating cost of health insurance, resulting in a negative impact on their finances, which will most likely worsen, given the escalating cost of health insurance, resulting in a [the remainder of this paragraph was apparently eradicated in electronic transmission and is reprinted as it was in the original.]

90. In reliance upon Defendant's misrepresentations, Plaintiff Mikulis and Class Members have been left in a worse financial position than they were; if not for Defendant's misrepresentations, Plaintiff Mikulis and Class Members would have, at the very least, made long term financial preparations that took into account the depletion of their financial resources due to ever increasing health care costs.

WHEREFORE, Plaintiffs request this Honorable Court grant Class Action status and find Plaintiff Mikulis and Class Members are entitled to:

(1) Repayment by Defendant of the full amount of money Plaintiff Mikulis and Class members have spent to procure health insurance benefits for participants and beneficiaries;

(2) Payment of a sum of money to Plaintiff Mikulis and Class Members sufficient to procure and maintain comparable insurance themselves and their beneficiaries;

(3) Payment for Plaintiff Mikulis' and Class Members' reasonable legal fees and costs of this action; and

(4) Any other legal and equitable relief as the Court may deem just and necessary.

Respectfully Submitted:

RIEDERS, TRAVIS, HUMPHREY, HARRIS, WATERS & WAFFENSCHMIDT

S/Clifford A. Rieders, Esquire

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May 17, 2004

CERTIFICATE OF SERVICE

AND NOW comes Clifford A. Rieders, Esquire, Attorney for Plaintiffs and Intervening Plaintiff Jean Mikulis, and certifies that a copy of the foregoing Second Amended Complaint of Intervenor Jean Mikulis has been served upon Kristofor Henning, Esquire and John Schultz, Esquire; Drinker Biddle & Reath; One Logan Square; Philadelphia, PA 19103-6996, this 17th day of May, by Electronic Filing.

RIEDERS, TRAVIS, HUMPHREY,
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WAFFENSCHMIDT

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[Exhibits Omitted In Printing]

(2)

No. 06-651

FILED
JAN 10 2007
OFFICE OF THE CLERK
SUPREME COURT, U.S.

In the Supreme Court of the United States

ELIZABETH MELLEY AND JEAN MIKULIS,
Petitioners,

v.

BLUE CROSS OF NORTHEASTERN PENNSYLVANIA,
Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Third Circuit

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BRIEF FOR RESPONDENT IN OPPOSITION

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WILSON-EPES PRINTING CO., INC. – (202) 789-0096 – WASHINGTON, D. C. 20001

QUESTION PRESENTED

Whether the Court of Appeals correctly concluded, applying the proper legal standard or the legal standard Petitioners themselves advocated, that Petitioners lacked standing to pursue claims for breach of fiduciary duty under the Employee Retirement Income Security Act of 1974 ("ERISA").

PARTIES TO THE PROCEEDING

Petitioners and Respondent Blue Cross of Northeastern Pennsylvania ("Blue Cross") were the only parties to the proceedings before the Court of Appeals.

RULE 29.6 CORPORATE DISCLOSURE STATEMENT

Blue Cross does not have a parent corporation and there is no publicly held company that owns 10% or more of its stock.

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In the Supreme Court of the United States

No. 06-651

ELIZABETH MELLEY AND JEAN MIKULIS,
Petitioners,

v.

BLUE CROSS OF NORTHEASTERN PENNSYLVANIA,
Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Third Circuit

BRIEF FOR RESPONDENT IN OPPOSITION

OPINIONS ENTERED BELOW

The Court of Appeals' opinion (Pet. App. 1-23) is reported at 454 F.3d 120 (3d Cir. 2006). Its order denying rehearing (Pet. App. 72-73) is unreported. The District Court has entered several decisions and orders, some of which are pertinent to the Petition. The District Court granted summary judgment in favor of Blue Cross and against the original plaintiffs with leave for the original plaintiffs to file an amended complaint. *Leuthner v. Blue Cross of Northeastern Pennsylvania*, 270 F. Supp. 2d 584 (M.D. Pa. 2003); Pet. App. 24-45. In unreported July 9, 2003 and August 10, 2004 decisions, the District Court denied class certification. The District Court's decisions dismissing Petitioners' claims for lack of standing are unreported. Pet. App. 46-57; Pet. App. 58-65.

INTRODUCTION

In 2001, Blue Cross amended an ERISA plan that provided and continues to provide employer contributions toward the health insurance of certain retirees. After the amendment, two Blue Cross retirees filed a putative class action against Blue Cross alleging that it breached its fiduciary obligations under ERISA by misrepresenting to them that they would receive greater employer contributions than were provided after the amendment. When those retirees were unsuccessful in their attempt at class certification, Petitioners (who are represented by the same counsel who represents the original retiree plaintiffs) intervened and attempted (unsuccessfully) to obtain certification of a class of their own. Not only did the District Court deny Petitioners' class certification motion, but it also dismissed their claims for lack of standing. The Court of Appeals subsequently affirmed the dismissal of Petitioners' claims.

In relevant part, ERISA permits only a "participant" or "beneficiary" to sue. 29 U.S.C. § 1132(a)(3). To satisfy ERISA's definition of "participant" or "beneficiary," a claimant must show that she is or may become eligible for, or entitled to benefits under, the relevant ERISA plan. 29 U.S.C. §§ 1002(7)-(8). In addition to the statutory definitions Congress provided in ERISA, this Court provided further guidance regarding the meaning of "participant" in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989). In this case, there is no dispute that after the 2001 amendment, Petitioners were no longer eligible for a contribution from Blue Cross toward their health insurance and could not take any action to become eligible for such a contribution. Under ERISA and *Firestone*, therefore, Petitioners could not qualify as "participants" or "beneficiaries."

The Petition does not claim that the Court of Appeals applied incorrect definitions of "participant" or "beneficiary" or did not apply this Court's guidance in *Firestone*. Instead,

it argues only that the Court of Appeals misapplied those settled legal principles and, furthermore, made erroneous factual conclusions in the course of its analysis. That is not a proper basis for review in this Court. Moreover, the Petition assumes Petitioners made factual allegations that they did not make in the courts below. Despite being permitted to amend her complaint, for instance, Petitioner Mikulis did not allege what she would have done without Blue Cross's alleged misrepresentations before her retirement that could have afforded her standing to sue. A petition for review in this Court cannot be used to cure pleading deficiencies in the courts below.

Petitioners have also suggested that the Court of Appeals' decision conflicts with those of other Courts of Appeals. Petitioners, however, have described the alleged conflict only in vague generalities. Moreover, for the only discrete legal issue on which the Courts of Appeals may disagree, the Court of Appeals in this case actually followed the legal rule Petitioners proposed. Even under that rule, however, the factual inadequacies in Petitioners' complaints prevent them from establishing standing.

STATEMENT OF THE CASE

A. The Parties

Blue Cross is a Pennsylvania non-profit corporation with its principal place of business in Wilkes-Barre, Pennsylvania. Pet. App. 7 (¶ 7). Petitioner Mikulis retired from Blue Cross in February 1993 with slightly less than thirteen (13) years of service. Pet. App. 3. Petitioner Melley is the widow of a deceased Blue Cross retiree. Pet. App. 4.

B. The Plan

Blue Cross sponsors and administers the Blue Cross of Northeastern Pennsylvania Retiree Health Insurance Plan ("the Plan"), which is an employee welfare benefit plan

subject to ERISA. Pet. App. 2. The Plan provides employer contributions toward the health insurance of eligible Blue Cross retirees based on their years of service. Pet. App. 2-3. From at least 1993 to January 1, 2001, Blue Cross contributed a percentage of the total cost of an eligible retiree's health insurance based on his/her years of service. Pet. App. 2-3. Also during that time, the Plan provided employer funded health insurance to surviving spouses of eligible Blue Cross retirees. Pet. App. 2-3.

Effective January 1, 2001, Blue Cross amended the Plan to provide for fixed dollar employer contributions toward an eligible retiree's health insurance, still based on his/her years of service. Pet. App. 3. As a result of the 2001 Plan amendment, retirees like Petitioner Mikulis with less than fifteen (15) years of service were no longer eligible to receive a contribution from Blue Cross toward their health insurance. Pet. App. 3. Also effective January 1, 2001, the Plan no longer provided employer funded health insurance to surviving spouses like Petitioner Melley. Pet. App. 3. Thus, after January 1, 2001, neither Petitioner was eligible for a contribution from Blue Cross toward her health insurance under the terms of the Plan.

C. Blue Cross Disclosed Its Right To Amend The Plan.

There is no question that Blue Cross was and is entitled to amend or terminate the Plan at any time. Indeed, as the Court of Appeals explained, Petitioners "no longer contend that the amendment of the plan constituted a breach of fiduciary duty." Pet. App. 5. Nor could they. Because the amendment of an ERISA welfare benefit plan does not constitute a "fiduciary act," it is clear that Blue Cross "did not violate ERISA by amending the Plan." Pet. App. 13 (citing *Lockheed Corp. v. Spink*, 517 U.S. 882, 890 (1996)). The Petition does not dispute that conclusion.

Not only did Blue Cross have the right to amend or terminate the Plan, but it publicly announced that right to its employees and retirees. In April 1993, for instance, Blue Cross distributed a Summary Plan Description ("SPD") for the Plan to its employees explaining that it could amend or terminate the benefits provided under the Plan. Pet. App. 80 (¶ 26); Pet. App. 103 (¶ 34); JA 85.[1] A memorandum that accompanied the SPD indicated that it "explains the health insurance benefits you may be entitled to should you retire from Blue Cross" and encouraged the reader to "familiarize yourself with this document." JA 79. Later, in August 1998, Blue Cross sent an SPD to its retirees indicating that it "reserves the right to modify or amend the Plan, in whole or in part, or terminate the Plan at any time and for any reason." Pet. App. 105 (¶ 50); JA 177; JA 173. Petitioners also attached to their complaint an additional document that disclosed Blue Cross's "right to change, modify or eliminate any benefit in the future." JA 93.

In fact, earlier in this litigation, the District Court found that "Blue Cross stated 'clearly and unequivocally' in SPDs that it reserved the right to modify or amend the Plan[.]" Pet. App. 37. The court further recognized that the Plan itself provided in 1993 (among other years) that "Blue Cross 'reserves the right to amend the Plan in any respect and to terminate the Plan for retirees at any time.'" Pet. App. 33. The Petition does not challenge either of these conclusions.

D. The District Court Properly Dismissed Petitioners' Claims.

Approximately two (2) years after Blue Cross disclosed the 2001 Plan amendment, two retirees filed a putative class action against Blue Cross in the United States District Court

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[1] References to "JA" are to exhibits to one or both Petitioners' complaints included in the joint appendix filed with the Court of Appeals.

for the Middle District of Pennsylvania. Pet. App. 24. The retirees alleged, *inter alia*, that Blue Cross breached its fiduciary duties under ERISA by misrepresenting to them that they would receive fully funded health insurance from Blue Cross for their entire lives. After the District Court denied the retirees' first motion for class certification, Petitioners intervened and asserted their own misrepresentation breach of fiduciary duty claims against Blue Cross on behalf of a putative class. Pet. App. 76-115.

The District Court rejected Petitioners' attempt at class certification and dismissed their claims because they were not "participants" or "beneficiaries" within the meaning of ERISA (29 U.S.C. §§ 1002(7) and (8)) and, therefore, lacked statutory standing. *Cf.* 29 U.S.C. § 1132(a)(3) (in relevant part, permitting only a "participant" or "beneficiary" to sue); Pet. App. 46-57; Pet. App. 58-65. In order to satisfy the definition of "participant" or "beneficiary" under ERISA, a plaintiff must show, *inter alia*, that she "is or may become eligible to receive [or entitled to] a benefit" under an ERISA plan. 29 U.S.C. § 1002(7); 29 U.S.C. § 1002(8). As a result of the January 2001 Plan amendment, however, there was no dispute that Petitioners were no longer eligible for benefits under the Plan and that they could not take any action to become eligible for Plan benefits. Pet. App. 52-53; Pet. App. 61-64. Therefore, Petitioners were not "participants" or "beneficiaries." The District Court rejected Petitioner Mikulis' argument that, although she was not a "participant" when she sued, the court should not dismiss her claims because "but for" Blue Cross's alleged fiduciary breach, she would have been a "participant." Pet. App. 53, 64. As the District Court explained, the January 2001 Plan amendment, not Blue Cross's alleged misrepresentations (its only alleged fiduciary breach), divested Petitioner Mikulis of her status as a "participant." Pet. App. 53, 64.

E. The Court Of Appeals Correctly Affirmed The District Court.

The Court of Appeals affirmed the District Court's decision. Pet. App. 1-21. The court applied the well-established definitions of "participant" and "beneficiary" Congress provided in ERISA as well as this Court's guidance regarding the meaning of "participant" in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989). Pet. App. 6-7. Relying on and applying these settled legal principles, the Court of Appeals addressed and rejected Petitioners' arguments for standing.

The Court of Appeals first rejected Petitioners' argument that they have standing because they fall within the "zone of interest" ERISA was intended to protect. Pet. App. 8-11. As the court noted, "it would make little sense for Congress to have enacted ERISA § 502(a)(1) to define who may bring suit . . . if standing to sue were to be determined by the traditional 'zone of interest' prudential standing test." Pet. App. 10. The Petition does not argue that this Court should accept review to determine whether a "zone of interest" test trumps the express list of persons Congress permitted to sue in § 502(a)(3) of ERISA (29 U.S.C. § 1132(a)(3)).

The Court of Appeals then applied *Firestone* and concluded that if Petitioners "raised a colorable claim of . . . a breach [of fiduciary duty] and detrimental reliance, then they would have standing because they would have a colorable claim to be eligible for equitable relief under § 502(a)(3)." Pet. App. 14. Petitioner Melley, however, could not establish standing under *Firestone*'s "colorable claim" test because Blue Cross's alleged fiduciary breach did not divest her of standing. Pet. App. 14. The January 2001 Plan amendment (which Petitioners do not contend violated ERISA's fiduciary obligations) did that. Pet. App. 14, 13, 5.

Petitioner Mikulis (but not Petitioner Melley) attempted to establish standing by arguing that "but for" Blue Cross's

alleged misrepresentations, she would have been a "participant" because she would have continued working to obtain at least fifteen (15) years of service and, therefore, would have been eligible for a contribution from Blue Cross toward her health insurance after the January 2001 Plan amendment. Pet. App. 14-18. Over Blue Cross's objection, the Court of Appeals adopted the "but for" theory of standing Petitioner Mikulis proposed and concluded that a plaintiff can establish standing by showing that "the alleged breach of fiduciary duty . . . has caused the claimant to lose status as a plan participant." Pet. App. 15, Pet. App. 15-17. Even under the legal test she requested, however, Petitioner Mikulis could not prevail. Petitioner Mikulis did not allege for how much longer she claims she would have worked at Blue Cross if she knew Blue Cross could amend the Plan — even though the District Court previously instructed her to allege with specificity the action or inaction she claimed to have taken in reliance on Blue Cross's alleged misrepresentations and the harm she claims to have suffered. Pet. App. 17; Pet. App. 56.[2] At times, the Petition attempts to correct that factual deficiency in Petitioner Mikulis' complaint by suggesting that she would have worked at Blue Cross long enough to obtain a contribution toward her health insurance after the January 2001 Plan amendment. The complaint itself (which obviously controls), however, does not include such an allegation. Thus, as the Court of Appeals explained: "There is no basis to conclude from the allegations in the complaint that, even if she had worked longer, she would still have qualified for benefits after the 2001 amendment." Pet. App. 17.

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[2] At the time Petitioner Mikulis retired, Blue Cross had not determined nor disclosed that fifteen (15) years of service would be required to obtain Plan benefits in 2001 and, therefore, it seems that she did not attach any significance to accumulating fifteen (15) years of service at that time. Pet. App. 17.

Finally, the Court of Appeals concluded that Petitioner Mikulis did not allege an actionable misrepresentation from Blue Cross. Pet. App. 17-18. "A representation is not a misrepresentation if it is an accurate reflection of the plan administrator's intent when the statement was made." Pet. App. 18. Because Petitioners (and specifically Petitioner Mikulis) did not allege that any representation from Blue Cross was false at the time it was made, the Court of Appeals concluded that "there is no ground to assert a breach of fiduciary duty." Pet. App. 18. In the Petition, Petitioners do not dispute that they did not allege a representation from Blue Cross that was false at the time it was made.

ARGUMENT

I. THE PETITION CONTENDS ONLY THAT THE COURT OF APPEALS MISAPPLIED PROPER LEGAL RULES OR REACHED ERRONEOUS FACTUAL CONCLUSIONS.

Review in this Court is generally not available where the Petition asserts only the misapplication of properly stated legal rules or erroneous factual conclusions by the lower court. Sup. Ct. Rule 10. That is precisely the case here. Petitioners do not complain that the Court of Appeals applied an incorrect legal rule or a legal rule that conflicts with a decision from this Court. Instead, they complain only about the court's application of settled legal principles and a legal rule they proposed as well as the court's reading of the allegations in their complaints. None of Petitioners' complaints presents sufficient reason for review.

In relevant part, ERISA permits only a "participant" or "beneficiary" to sue. 29 U.S.C. § 1132(a)(3). Congress provided statutory definitions of both "participant" and "beneficiary" and this Court provided further guidance regarding the meaning of "participant" in *Firestone*. 29 U.S.C.

§§ 1002(7)-(8); *Firestone*, 489 U.S. at 118. In *Firestone*, this Court explained:

> [T]he term "participant" is naturally read to mean either "employees in, or reasonably expected to be in, currently covered employment," or former employees who "have . . . a reasonable expectation of returning to covered employment" or who have "a colorable claim" to vested benefits. In order to establish that he or she "may become eligible" for benefits, a claimant must have a colorable claim that (1) he or she will prevail in a suit for benefits, or that (2) eligibility requirements will be fulfilled in the future. "This view attributes conventional meanings to the statutory language since all employees in covered employment and former employees with a colorable claim to vested benefits 'may become eligible.'"

Firestone, 489 U.S. at 117-18 (citation omitted). Petitioners do not dispute that the Court of Appeals applied the correct definitions of "participant" and "beneficiary" and also applied this Court's guidance in *Firestone* regarding the meaning of "participant" and, specifically, *Firestone*'s "colorable claim" test. Pet. App. 6-7; 11-18. Neither do Petitioners argue that *Firestone*'s guidance is incorrect. To the contrary, Petitioners claim only that the Court of Appeals misapplied both the definitions of "participant" and "beneficiary" from ERISA and the "colorable claim" test from *Firestone*. Pet. 13 ("The Third Circuit in this case did not properly apply this latter test [i.e., the "colorable claim" test].").

Petitioner Mikulis' claim that she has standing because she would have been a "participant" "but for" Blue Cross's alleged fiduciary breach (*i.e.*, its alleged misrepresentations) also does not provide a basis for review. At Petitioner Mikulis' request, the Court of Appeals ruled that a plaintiff can establish standing under ERISA by showing that "the alleged breach of fiduciary duty . . . has caused the claimant to lose status as a plan participant." Pet. App. 15, Pet. App.

15-17. Although Blue Cross does not believe the plain text of ERISA permits such a "but for" theory of standing, the Court of Appeals adopted the standard advocated by Petitioner Mikulis. Pet. App. 14 ("Mikulis has, however, raised a related argument — 'but for' Blue Cross's misrepresentations she would have retired later and would currently be a Plan participant.").

Even under that standard, however, Petitioner Mikulis could not establish standing. After several chances to file an adequate pleading, she still had not alleged how much longer she claims she would have worked at Blue Cross if she knew Blue Cross could amend or terminate the Plan — let alone that she would have obtained fifteen (15) years of service. Pet. App. 17-18. As explained above, the District Court previously instructed her to allege with specificity the action or inaction she claimed to have taken in reliance on Blue Cross's alleged misrepresentations and the harm she claims to have suffered. Pet. App. 56. As a result, there was and is no basis to conclude that Petitioner Mikulis would have been eligible for Plan benefits after the January 2001 Plan amendment. Pet. App. 17. This pleading deficiency cannot be corrected now, in a petition for review in this Court. Accordingly, even if this Court were to adopt the "but for" theory of ERISA standing Petitioner Mikulis proposed, the factual deficiencies in her complaint would preclude her from obtaining relief.

II. NO CONFLICT IN THE COURTS OF APPEALS WARRANTS REVIEW IN THIS COURT.

A. Petitioners' Vague Suggestion Of A Conflict Is Insufficient.

Petitioners argue that appellate caselaw "suggests" there is a conflict among the lower courts regarding the "method of applying standing principles such as those outlined in *Firestone*. . . ." Pet. 10. Petitioners fail, however, to describe

the alleged conflict with any specificity. The Petition does not, for example, describe (1) the alleged different "method[s] of applying" ERISA's definitions of "participant" and "beneficiary" or this Court's guidance in *Firestone*; (2) how those approaches allegedly differ; or (3) how review in this Court allegedly would affect this case — even assuming a conflict. Instead, Petitioners have contrasted what they characterize as "broad standing principles" and "more restrictive and narrow principles" without attempting to identify any legally distinct difference between the two. Pet. 11-12. Petitioners have left this Court to guess, therefore, what alleged conflict supposedly requires resolution.

In reality, Petitioners ask this Court to review the application of what they believe are correctly stated legal rules to particular allegations. For instance, Petitioners cite cases from within the same circuit that they claim adopt both broad and narrow ERISA standing principles. Pet. 11-12. In fact, Petitioners' citations reflect nothing more than the unremarkable proposition that courts reach different results with regard to ERISA standing in different cases based on different allegations. Pet. 11-12. That is not a basis for review in this Court.

B. The Third Circuit Followed The "But For" Theory Of ERISA Standing Petitioner Mikulis Proposed And, Therefore, Any Disagreement Regarding That Standard Provides No Occasion For Review In This Court.

It is true that the Courts of Appeals do not uniformly accept and apply the "but for" theory of ERISA standing Petitioner Mikulis urged and the Court of Appeals adopted in this case. Although some courts afford standing to a former "participant" or "beneficiary" who can show that "but for" the defendant's alleged fiduciary breach, he/she would still be a "participant" or "beneficiary," others do not. *Compare,*

e.g., *Leuthner v. Blue Cross of Northeastern Pennsylvania*, 454 F.3d 120, 128-29 (3d Cir. 2006) (Pet. App. 16); *Christopher v. Mobil Oil Corp.*, 950 F.2d 1209, 1221-23 (5th Cir.), *cert. denied*, 506 U.S. 820 (1992); *Vartanian v. Monsanto Co.*, 14 F.3d 697, 702-03 (1st Cir. 1994) *with Raymond v. Mobil Oil Corp.*, 983 F.2d 1528, 1536 (10th Cir.), *cert. denied*, 510 U.S. 822 (1993); *Stanton v. Gulf Oil Corp.*, 792 F.2d 432, 434-35 (4th Cir. 1986). Here, however, this disagreement was resolved in favor of Petitioner Mikulis, and she still could not establish standing.

As explained above, over Blue Cross's objection, the Court of Appeals in this case adopted the "but for" theory of standing Petitioner Mikulis proposed. Pet. App. 15; Pet. App. 15-17. Petitioner Mikulis could not establish standing even under the "but for" theory she requested because she did not allege (after several chances) how much longer she would have worked at Blue Cross if she had known Blue Cross could amend or terminate the Plan. That pleading failure provides no basis for review in this Court.

Petitioner Mikulis has suggested that the Court of Appeals improperly applied the "but for" theory of standing by using a "heightened pleading requirement." Pet. 13, 16. Petitioner Mikulis is incorrect and, in any event, her suggestion does not warrant review in this Court. The Court of Appeals did not apply a "heightened pleading standard" and Petitioner Mikulis has not cited any evidence that it did. Pet. 13, 16. Instead, the court correctly concluded that, after several chances, Petitioner Mikulis failed to make the factual allegation(s) necessary to support standing under her own "but for" theory, even though it is her burden to do so. Petitioner Mikulis, in fact, has not disputed that her complaint does not allege how much longer she claims she would have worked for Blue Cross if she had known it could amend the Plan. In other words, the critical allegation simply does not exist under any pleading standard. Not only that, but the

questions presented in the Petition do not mention an allegedly improper "heightened pleading standard" and, therefore, Petitioners cannot properly seek review in this Court on that basis. Moreover, Petitioner Mikulis claims, at most, that the Court of Appeals misapplied a legal rule she requested and made erroneous factual conclusions.

Petitioners also urge this Court to decide, as a matter of public policy, that a defendant may not deprive a claimant of ERISA standing through allegedly improper conduct that is alleged to violate ERISA. Pet. 10-11; 15. This Court, however, has already provided guidance regarding the definition of "participant" in *Firestone* and Petitioners do not argue that guidance is incorrect or should be revisited. In any event, Petitioners' public policy assertions do not merit review. Initially, to the extent Petitioners ask this Court to hold that they have standing because "but for" the January 2001 Plan amendment, they would have been "participants" or "beneficiaries," they have misunderstood their own claims. Pet. 15 ("Blue Cross should not be permitted to shield itself from liability for its false promise . . . by simply terminating the health benefits entirely."). As explained above, Petitioners do not claim that the January 2001 Plan amendment violated ERISA and the "but for" theory of standing Petitioner Mikulis proposed would apply only if the employer's conduct *alleged to violate* ERISA divested them of standing. Pet. App. 14. Moreover, the public policy considerations Petitioners cite are already incorporated into the "but for" theory of standing the Court of Appeals adopted in this case. Pet. App. 16 ("A plan administrator's alleged ERISA violation should not be the means by which the plan is able to insulate itself from suits arising from the alleged violation."). Even under the legal test that resulted from those policy considerations, however, Petitioners cannot establish standing because of the factual inadequacies in their complaints.

III. EVEN IF PETITIONERS HAD STANDING, THEIR PETITION DOES NOT PRESENT GROUNDS SUFFICIENT TO REVERSE THE COURT OF APPEALS' DECISION.

Petitioners have asked this Court to decide only whether they have standing to assert misrepresentation breach of fiduciary duty claims against Blue Cross. Pet. i-ii; Sup. Ct. Rule 14.1(a). Even if Petitioners had standing, however, their Petition does not present grounds sufficient to reverse the Court of Appeals' decision because they have not alleged an actionable misrepresentation from Blue Cross. Petitioners have not challenged the Court of Appeals' conclusion that "[a] representation is not a misrepresentation if it is an accurate reflection of the plan administrator's intent when the statement was made" or disputed the court's finding that their complaints did not allege any representation from Blue Cross that was false at the time it was made. Pet. App. 18; *Swinney v. General Motors Corp.*, 46 F.3d 512, 520 (6th Cir. 1995). Therefore, even if Petitioners had standing, they could not sustain their breach of fiduciary duty claims. Pet. App. 18.

CONCLUSION

The Petition should be denied.

Respectfully submitted,

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